MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH · COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural) near Lonaconing | LENGTH OF STAY (In this place): 44 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: R.F.D.1 Frostburg Md.

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural) near Lonaconing Md.
STREET ADDRESS (If rural, give location): R.F.D.1 Frostburg Md.

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) Edward (Last) Aldridge
4. DATE OF DEATH: (Month) Sept (Day) 12 (Year) 19 49
5. SEX: Male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single
8. DATE OF BIRTH: April 17-1891
9. AGE last birthday: 58 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinest helper
10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.
11. BIRTHPLACE (State or foreign country): Mt. Savage Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Geo. Leonard Aldridge
14. MOTHER'S MAIDEN NAME: Amanda Reed
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W.1
16. SOCIAL SECURITY NO.: 1-216-10-2305
17. INFORMANT: Mrs. Basil Pressman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

491 **Immediate cause** (a) Bronchopneumonia — Interval Between Onset and Death: about 5 days

107 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

H.V.Deming M.D. H.V. Deming M.D. Cumberland Md. Sept. 12-1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: Sept 15 '49 | NAME OF CEMETERY OR CREMATORY: Allegany Cemetery | LOCATION (City, town, or county) (State): Frostburg, Md

DATE REC'D BY LOCAL REG. 9/20/49 | REGISTRAR'S SIGNATURE: Jeanette M Goal | 24. FUNERAL DIRECTOR | ADDRESS: M. Erickson Lonaconing, Md

RECEIVED
SEP 24 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

08401

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 8

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing(rural); LENGTH OF STAY (In this place) 40 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS about 25 feet off of Jackson's Mt. road.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md.; COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing: Md.
STREET ADDRESS (If rural, give location) 13 Front St.

3. NAME OF DECEASED (Type or Print): (First) Hugh (Middle) H. (Last) Atkinson
4. DATE OF DEATH: (Month) Sept. (Day) 26 (Year) 1949

5. SEX: Male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Oct.18-1908
9. AGE last birthday: 40 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mgr. of a Confectionery store
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Lonaconing Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Hugh Atkinson
14. MOTHER'S MAIDEN NAME: Elizabeth Bell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. ------
17. INFORMANT: Wife) Mabel Beckman Atkinson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cardiac & pulmonary hemorrhage due to a	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) gunshot wound in left chest, self inflicted	
	(c)	

976
164 C

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Psychoneurotic

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Jackson's Mt. Rd. Lonaconing (CITY OR TOWN) Allegany (COUNTY) Md. (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour): Sept.26/49-8P about m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Self inflicted gunshot wound.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V.Deming M.D. H.V. Deming M.D. Cumberland Md. Sept 27-1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Sept 29, 1949
NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
LOCATION (City, town, or county): Cumberland, (State) Md.

DATE REC'D BY LOCAL REG. Sept 29 1949
REGISTRAR'S SIGNATURE Jannette M Boal
24. FUNERAL DIRECTOR M. Eichhorn
ADDRESS Lonaconing, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15A

RECEIVED
OCT 7 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08402

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH · COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage — LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Church Hill	STREET ADDRESS (If rural, give location): Church Hill

3. NAME OF DECEASED (Type or Print)	(First) CHARLES	(Middle) LEWIS	(Last) BAKER	4. DATE OF DEATH	(Month) Sept. (Day) 17, (Year) 1949
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married	8. DATE OF BIRTH: 6-20-1871	9. AGE last birthday: 78 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired machinist	10b. KIND OF BUSINESS OR INDUSTRY: C&P shops	11. BIRTHPLACE (State or foreign country): Mt. Savage, Md.	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME: Lewis Baker	14. MOTHER'S MAIDEN NAME: Katherine Hostettler				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service)	16. SOCIAL SECURITY No.: 220-16-2699	17. INFORMANT AND ADDRESS: Gladys Baker, Mt. Savage, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Heart Bloc	12 days
433.0 Antecedent cause(s)	(b) Heart Strain	14 days
95a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Thromo Phlebitis R Leg	1 week

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 5, 1949, to Sept 17, 1949, that I last saw the deceased alive on Sept 16, 1949, and that death occurred at 7:30 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): F. Alan E. Murray Mt. — ADDRESS: Cumberland — DATE SIGNED: Md

23. BURIAL, CREMATION REMOVAL (Specify): burial	DATE: 9-20-49	NAME OF CEMETERY OR CREMATORY: St. George Cemetery	LOCATION (City, town, or county) (State): Mt. Savage, Md.
DATE REC'D BY LOCAL REG.: Sept. 19-49	REGISTRAR'S SIGNATURE: Veronica McDermott	24. FUNERAL DIRECTOR: J. R. Durst, Frostburg, Md.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
SEP 21 1949
BUREAU V. S.

RECEIVED
21 1949
BUREAU V. S.

Within corporate limits

Evidence for addition in 18 shown on;

FILM No. G 122 OCT 26 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

08403

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gilmore
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital	STREET ADDRESS (If rural give location) —

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Sylvia	Elaine	Beeman		9	29	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Single	Jan 6-1948	1 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	none	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Cecil E. Beeman	Ora Anna Fazenbakes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No		Mrs Cecil Beeman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
237 Immediate cause	(a) Brain Tumor (astrocytoma)	7 10 mos.
56d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Non-malignant (10/26/49 - ans)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from February, 1949, to 9/29, 1949, that I last saw the deceased alive on 9/27, 1949, and that death occurred at 6:45 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Thomas Robinson	M.D.	19 S. Liberty St. Cumberland, Md.	9/30/49

23. BURIAL, CREMATION / REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Oct 1, 1949	Oak Hill Cemetery	Lonaconing	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 1, 1949	Walter R. Lantz, M.D.	M. Eichhorn	Lonaconing Md.

RECEIVED
OCT 4 1949
BUREAU V. S.

Berry

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

08404

Reg. Dist. No. 6

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport; LENGTH OF STAY (in this place) 38 yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS 220 Maryland Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport; STREET ADDRESS (If rural, give location) 220 Maryland Ave.

3. NAME OF DECEASED (Type or Print): (First) Goldie (Middle) Blanche (Last) Bothwell

4. DATE OF DEATH: (Month) Sept. (Day) 7 (Year) 19 49

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: Mar. 23, 1892

9. AGE last birthday: 57 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House-Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own-Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.

13. FATHER'S NAME: Edgar Micheal

14. MOTHER'S MAIDEN NAME: Margaret McBride

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT: Clarence Bothwell

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 Immediate cause (a) Cerebral hemorrage — Interval Between Onset and Death: 3hrs

83a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) hypertension — ?

(c) Arteriosclerosis — 1yr.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 28, 19 48, to Sept 7, 19 49, that I last saw the deceased alive on Sept. 7, 19 49, and that death occurred at 3p m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

F.E. Berry M.D. Piedmont W. Va. Sept. 9-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Sept. 10, 1949 — NAME OF CEMETERY OR CREMATORY: Philos — LOCATION (City, town, or county) (State): Westernport, Maryland

DATE REC'D BY LOCAL REG. Sept. 9/49 — REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR: E.S. Boal — ADDRESS: 111 Church St. Westernport, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
SEP 12 1949
BUREAU V. S.

DR. VAN ORMER

Within corporate limits

68405

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY: ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: MARYLAND COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND — LENGTH OF STAY (in this place): 94 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: ~~Our~~ CUMBERLAND, ~~MD~~ Rural
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location): ROUTE # 2

3. NAME OF DECEASED (Type or Print)	(First) EPHRIAM	(Middle)	(Last) BROWNING	4. DATE OF DEATH	(Month) SEPT. (Day) 24 (Year) 1949
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED	8. DATE OF BIRTH: MAY 18, 1872	9. AGE last birthday: 77 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~RETIRED~~ Farmer	10b. KIND OF BUSINESS OR INDUSTRY: Farming	11. BIRTHPLACE (State or foreign country): MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME: GEORGE BROWNING	14. MOTHER'S MAIDEN NAME: MASSIE SMITH				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)	16. SOCIAL SECURITY No.: None	17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
420.0 Immediate cause	(a) Arteriosclerotic Heart Disease with	?
Antecedent cause(s)	auricular Fibrillation and Cardiac failure.	
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) Generalized arteriosclerosis	?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1 July, 1949, to 24 Sept., 1949, that I last saw the deceased alive on 23 Sept., 1949, and that death occurred at 3 30 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W. Alfred Van Ormer		Cumberland, Md.	26 Sept. 49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Sept. 26, 1949	Hillcrest Cemetery	Cumberland, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 26, 1949	Winter R. Frantz, M.D.	John J. Hafer, Cumberland, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

VS-A15

RECEIVED
OCT 4 1949
BUREAU T. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

08406

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 12 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: dead on arrival at Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 1017 Gay St.

3. NAME OF DECEASED (Type or Print): (First) Anna (Middle) (Last) Bryant

4. DATE OF DEATH: (Month) Sept. (Day) 13 (Year) 1949

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: May 15-1908

9. AGE last birthday: 41 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Pa.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Miller

14. MOTHER'S MAIDEN NAME: Elsie Deneen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: -------

17. INFORMANT: son

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
171 Immediate cause	(a) Uremia	?
48a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) due to ureteral obstruction	
	(c) carcinoma of the cervix	several months

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V.Deming M.D. H.V. Deming M.D. Cumberland Md. Sept. 13-1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: 9/16/49

NAME OF CEMETERY OR CREMATORY: Odd Fellows Cem

LOCATION (City, town, or county) (State): Berlin, Pa.

DATE REC'D BY LOCAL REG.: Sept. 15, 1949

REGISTRAR'S SIGNATURE: Walter R. Beatty, M.D.

24. FUNERAL DIRECTOR: James F. Scarpelli

ADDRESS: Cumberland, Md.

VS. A15A

RECEIVED
SEP 20 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

8467

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Lonaconing
LENGTH OF STAY (In this place): 69 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: (Detmoid)

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Lonaconing
STREET ADDRESS (If rural, give location): (Detmoid)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
James	George	Cameron	Sept.	18	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	white	widower	May 17-1880	69 yrs.				

10a. USUAL OCCUPATION (Give kind of wnrk done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
miner	coal	Lonaconing Md.	U.S.A.

13. FATHER'S NAME: Archibald Cameron

14. MOTHER'S MAIDEN NAME: Jane Mc Luckie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	217-03-2150	son) Arch Cameron

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
422.1 **Immediate cause**	(a) Chronic myocarditis	about 10 years
93d **Antecedent cause(s)** Diseases nr conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) Arterio sclerosis	?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death hut nnt related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an Autopsy* ☐, *Inspection* ☒, *Inquiry* ☒ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H. V. Deming M.D.	Cumberland Md.	Sept.18-1949

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Sept 21, 49	Oak Hill Cemetery	Lonaconing, Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9/20/49	Jeannette M Boal	M. Eichhorn	Lonaconing, Md

RECEIVED
SEP 21 1949
BUREAU Y. S.

Within corporate limits

DR. DYER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08408

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

I

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: ALLEGANY — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 27 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital, Cumberland, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 613½ Louisiana Ave.,

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Charles	Thomas	Carney	Sept.	25	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
MALE	WHITE	MARRIED	AUG. 10 1883	66 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Supt Reclamation Plant	B & O Railroad	Milwaukee, Wisconsin	US

13. FATHER'S NAME: GEORGE A. CARNEY

14. MOTHER'S MAIDEN NAME: SARAH BROWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	705-09-3111	Mrs Bertha Carney 613½ Louisana Ave Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
331 Immediate cause (a)	Cerebral Hemorrhage	8 hrs
61 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	Hypertension	6 yr.
(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Diabetes mellitus	8 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 9-24, 1949, to 9-25, 1949, that I last saw the deceased alive on 9-25-49 19..., and that death occurred at 7-10 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
John G. Dyer, M.D.		247 Virginia Ave	9-25-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Sept 28 1949	Hill Crest Buria l Park	Cumberland, Maryland.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 27, 1949	Wurster K. Lantz, M.D.	William H. Kight	Cumberland, Md.

RECEIVED
OCT 4 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08409

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Red Hill
LENGTH OF STAY (in this place) Lifetime
HOSPITAL OR INSTITUTION OR STREET ADDRESS R. L. No 1 Cumberland Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Red Hill
STREET ADDRESS (If rural, give location) R. T. L. No 1 Cumberland Md.

3. NAME OF DECEASED (Type or Print) (First) John (Middle) Henry (Last) Clesterman

4. DATE OF DEATH (Month) 9 (Day) 5 (Year) 1944

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH Mar. 2 - 1875
9. AGE last birthday 74 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner
10b. KIND OF BUSINESS OR INDUSTRY Coal Mines
11. BIRTHPLACE (State or foreign country) Barton, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME John H. Clesterman
14. MOTHER'S MAIDEN NAME Catherine Cook

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS 113 Bedford St. Mrs Marie Logsdon Cumberland Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443 Immediate cause (a) Hypertensive Heart Disease with Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: 10 years

Antecedent cause(s)

82 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c) Pernicious anemia with Posterior Lateral Sclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1 Jan., 1938, to 5 Sept., 1949, that I last saw the deceased alive on 1 Sept., 1949, and that death occurred at 9:35 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) W. Alfred Van Orme
ADDRESS Cumberland, Md.
DATE SIGNED 6 Sept 49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 9-8-1949
NAME OF CEMETERY OR CREMATORY S. S. Peter & Paul's Cem.
LOCATION (City, town, or county) Cumberland, Md. (State)

DATE REC'D BY LOCAL REG. 9-7-49
REGISTRAR'S SIGNATURE Mrs Nancy H. Roe
24. FUNERAL DIRECTOR Jacob Hafer
ADDRESS Frostburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 12 1949
BUREAU V. S.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08410

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) I Month
HOSPITAL OR INSTITUTION OR STREET ADDRESS 604 Bedford St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) Rear Ormand St No I7

3. NAME OF DECEASED (Type or Print) (First) Gerrett (Middle) Monroe (Last) Cole

4. DATE OF DEATH (Month) 9- (Day) 29-I949 (Year) 19

5. SEX Male

6. COLOR OR RACE Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 3-4-I874

9. AGE last birthday 75 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10b. KIND OF BUSINESS OR INDUSTRY P. W. A.

11. BIRTHPLACE (State or foreign country) Moorefield, W. Va

12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Anna Peck

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY No. None

17. INFORMANT AND ADDRESS Ernest Cole, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
443	Immediate cause	(a) 2nd Cerebral Hemorrhage	3 days
93d	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension Heart Disease	2 yrs
		(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cerebral Hemorrhage with Left side Paralysis — 2 years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 25, 1949, to Sept 29 1949, that I last saw the deceased alive on Sept 28, 1949, and that death occurred at 11 15 a m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

F. Alan G. Murray Not Cumberland Md

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE I0-2-I949

NAME OF CEMETERY OR CREMATORY Allegany Cem.

LOCATION (City, town, or county) (State) Frostburg, Md.

DATE REC'D BY LOCAL REG. Oct. 1, 1949

REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR Jacob Hafer ADDRESS Frostburg, Md.

RECEIVED
OCT 4 1949
EUROPEAN T. S.

Within corporate limits

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS AT

I

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08411

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 28 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 232 Baltimore Ave.

3. NAME OF DECEASED (Type or Print) (First) Linne (Middle) Harold (Last) Corson

4. DATE OF DEATH (Month) (Day) (Year) September 23 1949

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced

8. DATE OF BIRTH March 11, 1885

9. AGE last birthday 64 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Goshen, New Jersey

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James Corson

14. MOTHER'S MAIDEN NAME Emma Grace

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) No

16. SOCIAL SECURITY NO. None

17. INFORMANT AND ADDRESS Avalon C. Kandle, Sea Isle City, N.J.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
331	Immediate cause	(a) Cerebro vascular accident	4 hrs
	Antecedent cause(s)		
83a	Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/23, 19.., to 9/23, 1949, that I last saw the deceased alive on 9/23, 1949, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

George M Simons M.D Cumberland, Md Sept 23, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE Sept. 26, 1949

NAME OF CEMETERY OR CREMATORY South Dennis Cemetery

LOCATION (City, town, or county) (State) South Dennis, N. Jersey

DATE REC'D BY LOCAL REG. Sept. 25, 1949

REGISTRAR'S SIGNATURE Winter K. Frantz M.D

24. FUNERAL DIRECTOR John J. Hofer, Cumberland, Md. ADDRESS

RECEIVED
OCT 4 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

018412

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage
STREET ADDRESS (If rural, give location) [redacted] St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Agnes	Clara	Crowe	Sept.	18	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Widowed	12/26/1869	79 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own home	Mt Savage Maryland	U.S.A.

13. FATHER'S NAME: John H. Maser

14. MOTHER'S MAIDEN NAME: Mary A. Weimer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	None	Harry Crowe

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)	Myocardial failure	2½ mos.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	Chronic myocarditis	3 yrs.
(c)	Senility	

422.2
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Dec, 1946, to Sept. 18, 1949, that I last saw the deceased alive on Sept. 17, 1949, and that death occurred at 6:50 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones	M.D.	110 S. Centre St.	Sept. 19, 1949

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Sept. 21, 1949	Methodist Cemetery	Mt. Savage, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 19, 1949	Wrates R. Fantz, M.D.	Durst Funeral Home	Cumberland, Md.

VS. A15

RECEIVED
SEP 27 1949
BUREAU V. S.

Within corporate limits

08413

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-115

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 78 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 25 Hawthorne Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 25 Hawthorne Ave.

3. NAME OF DECEASED (Type or Print) (First) Cora (Middle) May (Last) Davis

4. DATE OF DEATH (Month) Sept (Day) 21 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Sept 29 1870
9. AGE last birthday 78 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10b. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (State or foreign country) Cumberland Md
12. CITIZEN OF WHAT COUNTRY U S A.

13. FATHER'S NAME Theodore Valentine
14. MOTHER'S MAIDEN NAME Mary C Wolfe.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Mrs Ambrose Buckley, Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

442 Immediate cause (a) Cardio-Renal

Antecedent cause(s)

131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertention,

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 1949, to Sept 21, 1949, that I last saw the deceased alive on Sept 20, 1949, and that death occurred at 8 05 P.m., from the causes and on the date stated above.

SIGNATURE T Bailey Hunter (Degree or title) MD ADDRESS Cumberland Md DATE SIGNED 9/22/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Sept 24 '49
NAME OF CEMETERY OR CREMATORY Hillcrest Cem
LOCATION (City, town, or county) Cumberland (State) Md.

DATE REC'D BY LOCAL REG. Sept. 23, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Louis Stein Inc ADDRESS Cumberland

RECEIVED
OCT 4 1949
BUREAU V. S.

Within corporate limits

Richard Wims

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

T

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08414

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 40 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland Md.
STREET ADDRESS (If rural, give location) 42 Thomas St.

3. NAME OF DECEASED (Type or Print) (First) Mrs (Middle) Margaret Ann (Last) Davis

4. DATE OF DEATH (Month) Sept (Day) 21 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH 12/23/66
9. AGE last birthday 82 yrs. If under Months. I year Days If under Hours 24 hrs. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10b. KIND OF BUSINESS OR INDUSTRY at Home
11. BIRTHPLACE (State or foreign country) Manns Choice Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Phillip Keel
14. MOTHER'S MAIDEN NAME Rebecca Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Sherman Keel - 30 Orchard St. City

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma Head of Pancreas — INTERVAL BETWEEN ONSET AND DEATH 6 mo.

157

Antecedent cause(s)

46g

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
(CITY OR TOWN) Cumberland (COUNTY) Alleg (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 8/12/47, 19....., to 9/21/49, 19....., that I last saw the deceased alive on 9/20/49 19..... and that death occurred at 6 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) B. H. Williams MD ADDRESS Cumberland Md DATE SIGNED 9/22/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 9/23/49
NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. Sept. 22, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz M.D.
24. FUNERAL DIRECTOR John J. Hafer ADDRESS Cumberland Md

RECEIVED
SEP 27 1949
BUREAU V. S.

Within corporate limits

DR. ~~GRACIE~~ Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08415

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Pennsylvania COUNTY Bedford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, LENGTH OF STAY (in this place) 17 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BEDFORD
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL Hospital	STREET ADDRESS (If rural, give location) 728 JULIANA STREET, ✓

3. NAME OF DECEASED (Type or Print)	(First) ROSE	(Middle) H	(Last) DONAHOE	4. DATE OF DEATH	(Month) SEPT. (Day) 10 (Year) 1949
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JUNE 10, 1873	9. AGE last birthday 76 yrs.	If under 1 year Months / Days; If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) NEBRASKA	12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME HUGHES, FRANCIS	14. MOTHER'S MAIDEN NAME DOLLARD, MARY				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT MEMORIAL HOSPITAL			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
600.0	Immediate cause	(a) Bronchopneumonia	4 days
133a	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Pyelonephrosis	?
		(c) Chronic Auricular Fibrillation	?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 8-24, 1949, to 9-10-, 1949, that I last saw the deceased alive on 9-10, 1949 and that death occurred at 8:45 p.m., from the causes and on the date stated above.

SIGNATURE W. F. Williams (Degree or title) ADDRESS MD - Cumberland DATE SIGNED 9-12-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 9-13-49	NAME OF CEMETERY OR CREMATORY St. Thomas Cem.	LOCATION (City, town, or county) (State) Bedford, Penna.
DATE REC'D BY LOCAL REG. Sept. 11, 1949	REGISTRAR'S SIGNATURE Winter R. Lantz, M.D.	24. FUNERAL DIRECTOR S. Alton Barefoot	ADDRESS Bedford, Pa.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 20 1949
U. S. BUREAU

Within corporate limits

DR. TOLSON
Evidence for changes
in #3,7,14, shown on:
FILM No. G 125 MAY 8 1950

Case 1454

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08416

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: ALLEGANY
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 6 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND
COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: MIDLOTHIAN Rural
STREET ADDRESS (If rural, give location): Rural Frostburg, Maryland

3. NAME OF DECEASED (Type or Print): (First) ~~ALBERT~~ Alfred (Middle) C. (Last) DREW

4. DATE OF DEATH: (Month) SEPT. (Day) 21 (Year) 1949

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): mar ~~WIDOWED~~

8. DATE OF BIRTH: July 28, 1883

9. AGE last birthday: 66 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mines

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: EDGAR DREW

14. MOTHER'S MAIDEN NAME: Ameila ~~COOPER~~ Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service)

16. SOCIAL SECURITY No.: 214-14-1849

17. INFORMANT AND ADDRESS: Edward Drew, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Nephritis, with Uremia

Antecedent cause(s) (b) Benign Hypertrophy Prostate

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

610
131b

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-15-, 1949, to 9-21-, 1949, that I last saw the deceased alive on 9-20-, 1949, and that death occurred at 8 55 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Edward Tolson, MD ADDRESS: Cumberland, Md. DATE SIGNED: 9-22-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: Sept 25 1949
NAME OF CEMETERY OR CREMATORY: Allegany Cemetery
LOCATION (City, town, or county) (State): Frostburg, Maryland

DATE REC'D BY LOCAL REG.: Sept. 23, 1949
REGISTRAR'S SIGNATURE: Winter K. Frantz, M.D.

24. FUNERAL DIRECTOR: Joseph Durst, ADDRESS: Frostburg, Maryland

VS. 415

RECEIVED
SEP 27 1949
BUREAU T. B.

Within corporate limits

Dr. W. F. Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

08417

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 25 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 24 Queen Street
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital	STREET ADDRESS (If rural, give location) Mc Coole, Maryland

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Mrs. Anna V. Duckworth				4. DATE OF DEATH (Month) (Day) (Year) Sept. 17, 1949			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH June 21, 1878	9. AGE last birthday 71 yrs.	If under 1 year Months	Days	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Thomas Berry			14. MOTHER'S MAIDEN NAME Ella Kline				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT Memorial Hospital				

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Peritonitis — 2

570.5 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Ulcerative colitis — Mo

122b (c) Intestinal Obstruction

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☑ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-22, 1949, to 9-17-, 1949, that I last saw the deceased alive on 9-17-, 1949, and that death occurred at 10:05 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W. F. Williams	M.D.	Cumberland	9-17-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	9-20-49	Queens Point Cemetery	Keyser	W.Va

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 18, 1949	Winter R. Frantz, M.D.	B. W. Markwood	Keyser W.Va

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 27 1949
BUREAU V. S.

Within corporate limits

Evidence for addition of #18c shown on: FILM No. G 122 OCT 28 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

018418

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY ALLEGANY; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND; LENGTH OF STAY (In this place) 48 YRS; HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND; COUNTY ALLEGANY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND; STREET ADDRESS (If rural, give location) 828 SHAWNEE AVENUE

3. NAME OF DECEASED (Type or Print): (First) LAURA (Middle) V. (Last) FOGLE

4. DATE OF DEATH: (Month) SEPT. (Day) 20, (Year) 1949

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED

8. DATE OF BIRTH: JULY 10 1870

9. AGE last birthday: 79 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: at Home

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: George Powell

14. MOTHER'S MAIDEN NAME: Martha DEVILBISS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY No.: None

17. INFORMANT: Mrs. Geo. F. Bennett, Married Dtr

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

442 Immediate cause (a) Cardiac failure

Interval between onset and death:

131a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Uremia

(c) Hypertensive Cardio vascular renal disease. (10/28/49 a.s.)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb, 1949, to Sept, 1949, that I last saw the deceased alive on Sept 14, 1949, and that death occurred at 6 PM m., from the causes and on the date stated above.

SIGNATURE (Degree or title) George M Brown M.D. ADDRESS 128 Union St Cumberland Md DATE SIGNED 9/20/49

23. BURIAL, CREMATION / REMOVAL (Specify): Burial

DATE THEREOF: Sept 23 49

NAME OF CEMETERY OR CREMATORY: Mt Olivet Cem

LOCATION (City, town, or county): Frederick

(State): Md

DATE REC'D BY LOCAL REG.: Sept. 22, 1949

REGISTRAR'S SIGNATURE: Winter R. Beatty, M.D.

24. FUNERAL DIRECTOR: Louis Stein Inc

ADDRESS: Cumberland

VS. A15

RECEIVED
SEP 27 1949
BUREAU V. S.

Within corporate limit

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

18419

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. — COUNTY: Garrett
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Friendsville
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Betty (Middle) Jean (Last) Friend

4. DATE OF DEATH: (Month) Sept. (Day) 26 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: Sept. 9-1949

9. AGE last birthday: 0 yrs. — If under 1 year: Months — Days 17 — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -----

10b. KIND OF BUSINESS OR INDUSTRY: -----

11. BIRTHPLACE (State or foreign country): Cumberland Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Reed L. Friend

14. MOTHER'S MAIDEN NAME: Mildred Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY No.: ------

17. INFORMANT: Hospital records

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute cardiac failure	2 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Pulmonary edema	5 hrs.
772.0 161c	(c) Malnutrition	about 1 week.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY: (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy* ☒, *Inspection* ☒, *Inquiry* ☒ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D. H.V. Deming M.D.	Cumberland Md.	Sept. 26-1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Sept. 27 1949	Blooming Rose Cemetery	Friendsville, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 27 1949	Winter K. Frantz M.D.	W. W. Savage,	Friendsville, Maryland

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

RECEIVED
OCT 4 1949
BUREAU V. S.

Within corporate limits

08420

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
LENGTH OF STAY (in this place): Lifetime
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 307 Mt. View Drive

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. — COUNTY: Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
STREET ADDRESS (If rural, give location): 307 Mountain View Drive

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Aloysius (Last) Glick
4. DATE OF DEATH: (Month) Sept. (Day) 24 (Year) 1949
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: March 6th 1891
9. AGE last birthday: 58 yrs. — If under 1 year: Months 6, Days 18 — If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lumber yard foreman
10b. KIND OF BUSINESS OR INDUSTRY: Lumber
11. BIRTHPLACE (State or foreign country): Cumberland, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Joseph M. Glick
14. MOTHER'S MAIDEN NAME: Margaret Gramlich
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service)
16. SOCIAL SECURITY No.: 220-10-7475
17. INFORMANT AND ADDRESS: Lucy McKenzie Glick

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Tuberculosis — 9 mon

008

Antecedent cause(s)

13b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar, 1949, to Sept 24, 1949, that I last saw the deceased alive on Sept 24, 1949, and that death occurred at 2:30 P m., from the causes and on the date stated above.

SIGNATURE: George M Simons — (Degree or title) M.D. — ADDRESS: 128 Union St. Cumb. Md. — DATE SIGNED: 9/27/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Sept. 27 1949 — NAME OF CEMETERY OR CREMATORY: S.S. Peter & Paul Cem. — LOCATION (City, town, or county): Cumberland, Maryland (State)

DATE REC'D BY LOCAL REG.: Sept. 27, 1949 — REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D. — 24. FUNERAL DIRECTOR: Louis Stein, Inc. — ADDRESS: Cumberland, Md.

M

I

T

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 4 1949
BUREAU V. S.

Outside of City Limits

08421

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural near Cumberland
LENGTH OF STAY (in this place) 51 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Christie Road Route #4 Cumberland Md

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN R.F.D. #4 Cumberland Md.
STREET ADDRESS (If rural, give location) R.F.D. #4 Christie Road

3. NAME OF DECEASED (Type or Print) (First) John (Middle) Wm. (Last) Grabenstein
4. DATE OF DEATH (Month) Sept (Day) 16 (Year) 1949
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH 3/16/1865
9. AGE last birthday 84 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY General Farming
11. BIRTHPLACE (State or foreign country) Cresaptown, Md
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Justice Grabenstein
14. MOTHER'S MAIDEN NAME Margaret Munday
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Mrs Frances Briner

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

450.0 Immediate cause (a) Myocardial Failure 4 hrs

59 b Antecedent cause(s) (b) Arterio Sclerosis Unknown

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Arthritis, hypertrophy Unknown

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 9, 1949, to Sept 16, 1949, that I last saw the deceased alive on Sept 16, 1949, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE [signature] (Degree or title) ADDRESS Vo 4 Decatur St Cum Md DATE SIGNED 9/19/49

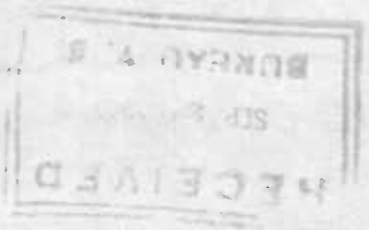
23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 9/19/49
NAME OF CEMETERY OR CREMATORY St Peters & Pauls Cath Cem
LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. Sept. 19, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR John J. Hafer ADDRESS Cumberland Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15


RECEIVED
BUREAU

White [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

108422

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 319 Williams St.,

3. NAME OF DECEASED (Type or Print): (First) John Addis (Middle) Ewing (Last) Graham

4. DATE OF DEATH: (Month) Sept. (Day) 4, (Year) 19 49

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: July 30, 1866

9. AGE last birthday: 83 yrs. If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Sheet Metal

11. BIRTHPLACE (State or foreign country): Green Co. Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Samuel A. Graham

14. MOTHER'S MAIDEN NAME: Mary Jolly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: 234-26-1912

17. INFORMANT: Samuel A. Graham

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

592 **Immediate cause** (a) Myocardial Failure — Interval between onset and death: ?

Antecedent cause(s)

61 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Coronary Artery Disease (Atherosclerosis)

(c) Chronic diffuse Glom. Nephritis ?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/31, 19 49, to 9/4, 19 49, that I last saw the deceased alive on 9/3, 19 49, and that death occurred at 8:30 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Samuel A. Graham M.D. ADDRESS Cumberland, Md. DATE SIGNED 9/6/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: 9-7-1949

NAME OF CEMETERY OR CREMATORY: Sunset Cem.

LOCATION (City, town, or county) (State): Clarksburg, W. Va.

DATE REC'D BY LOCAL REG.: Sept. 6, 1949

REGISTRAR'S SIGNATURE: Chester K. Frantz, M.D.

24. FUNERAL DIRECTOR: H. Wayne George ADDRESS: Cumberland, Md.

RECEIVED
SEP 14 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

08423

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 172 Ormond St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) 172 Ormond St.

3. NAME OF DECEASED (Type or Print): (First) KATHERINE (Middle) (HARTIG) (Last) GRIFFITH

4. DATE OF DEATH: (Month) Sept. (Day) 21 (Year) 1949

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: 11-16-1873

9. AGE last birthday: 75 yrs. If under 1 year: Mooths. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Frostburg, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Hartig

14. MOTHER'S MAIDEN NAME: Mary Zais

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Mrs. Olive Duncan, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 **Immediate cause** (a) Chronic myocarditis. — Interval Between Onset and Death: One year.

93d **Antecedent cause(s)**

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Senility

(c) Arterial sclerosis.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Secondary anemia.

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-1, 1949, to 9-21, 1949, that I last saw the deceased alive on 9-21, 1949 and that death occurred at 4:30 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H. C. Diehl, M.D. Frostburg, Md. 9.23.49.

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 9-24-49 — NAME OF CEMETERY OR CREMATORY: Allegany Cemetery — LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 9-23-49 — REGISTRAR'S SIGNATURE: Mrs. Hazel H. Roe

24. FUNERAL DIRECTOR — ADDRESS: J. R. Durst, Frostburg, Md.

RECEIVED
SEP 26 1949
BUREAU T. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08424

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany. STATE: MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland. LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 451 Goethe St.	STREET ADDRESS (If rural, give location): 451 Goethe St.

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Edward		Hadra.		Sept	9	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Widowed	Dec 15, 1867	81 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Letter Carrier	U.S. Post Office	Waverly Ohio.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Edward Hadra	Mary Schultz.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	None	Edward H. Hadra, Flushing, L.I.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 **Immediate cause** (a) Cardiac failure — Interval between onset and death: 1 hr

83a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Cerebro-vascular accident c — 2 yr

(c) paralysis rt. side

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from Sept 9, 1949, to ....., 19....., that I last saw the deceased alive on Sept 9, 1949 and that death occurred at 10:45 P. m., from the causes and on the date stated above.

SIGNATURE: John G. Dyer (Degree or title) M.D. ADDRESS: 247 Virginia Ave. DATE SIGNED:

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Sept 12, 1949	Hillcrest Cemetery	Cumberland	Md.

DATE REC'D BY LOCAL REG'R	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept 12, 1949	Wynter K. Hantz, M.D.	John J. Hafer.	Cumberland Md.

VS. A15

RECEIVED
SEP 20 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08425

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 328 Fayette St.,

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 328 Fayette St.,

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) EFFIE (Last) HAST

4. DATE OF DEATH: (Month) Sept. (Day) 29, (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Sept. 22/1869

9. AGE last birthday: 80 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dept. store clerk

10b. KIND OF BUSINESS OR INDUSTRY: Store

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Caspar Hast

14. MOTHER'S MAIDEN NAME: Frances Ryland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mary A. Ryland 422 N. Mechanic St., Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

191 Immediate cause (a) Carcinoma of face — Interval between onset and death: 2 yrs.

53 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Chronic myocarditis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1947 to Sept. 28, 1949 that I last saw the deceased alive on Sept 28, 1949, and that death occurred at 12.05 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Charlotte B. Gardner M.D. 126 Columbia St Cumberland Md. Sept. 29, 49

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE: Oct. 1, 1949

NAME OF CEMETERY OR CREMATORY: Rose Hill

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Sept. 30, 1949

REGISTRAR'S SIGNATURE: Lourtes K. Hartz, M.D.

24. FUNERAL DIRECTOR: H. Wayne George ADDRESS: Cumberland, Md.

RECEIVED
OCT 4 1949
BUREAU V. S.

Within corporate limits DR. WHITWORTH

M

C

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08426

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD. LENGTH OF STAY (in this place) 2 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY a.a.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE, MARYLAND
STREET ADDRESS (If rural, give location) 2466 FOURTH STREET ✓

3. NAME OF DECEASED (Type or Print) (First) BABY (Middle) GIRL (Last) HEPBURN
4. DATE OF DEATH (Month) (Day) (Year) 19 9-24-49

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE
8. DATE OF BIRTH 9-22-49
9. AGE last birthday 2 DAYS yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME CHARLES HEPBURN
14. MOTHER'S MAIDEN NAME RUTH L. RICHARDS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL, MEMORIAL AVE.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

776 Immediate cause (a) Prematurity 6½ mo

Antecedent cause(s)

159 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 22 Sept, 1949, to 24 Sept, 1949, that I last saw the deceased alive on 24 Sept, 1949 and that death occurred at 2:45 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Fuller B. Whitworth ADDRESS Cumberland DATE SIGNED 26 Sept 49

23. BURIAL, CREMATION REMOVAL (Specify) CREMATION
DATE SEPT. 26, 1949
NAME OF CEMETERY OR CREMATORY MEMORIAL HOSPITAL
LOCATION (City, town, or county) (State) CUMBERLAND, MD.

DATE REC'D BY LOCAL REG. Sept. 26, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Memorial Hosp., Cumberland, Md. ADDRESS

RECEIVED
OCT 4 1949
BUREAU V. S.

DR. WHITWORTH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

118427

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 2 days
STATE: MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND
COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
STREET ADDRESS (If rural, give location): 717 SHAWNEE AVENUE

3. NAME OF DECEASED (Type or Print): (First) Baby Boy (Middle) Harry (Last) HIMMLER, Jr.

4. DATE OF DEATH: (Month) SEPT. (Day) 12 (Year) 1949

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Child

8. DATE OF BIRTH: SEPT. 10, 1949

9. AGE last birthday: yrs. If under 1 year: Months; Days: 2; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): CUMBERLAND, MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ROBERT HIMMLER Sr. (Harry)

14. MOTHER'S MAIDEN NAME: MARY MORRIS (Louise)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Sclerema — 773.0

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last — (b) 161c

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10 Sept, 1949 to 12 Sept, 1949 that I last saw the deceased alive on 12 Sept, 1949, and that death occurred at 6:50 PM m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Fuller B. Whitworth — ADDRESS: Cumberland, Md — DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Sept. 13, 1949 — NAME OF CEMETERY OR CREMATORY: St. Lukes Lutheran — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Sept. 13, 1949 — REGISTRAR'S SIGNATURE: Walter L. Kantz, M.D.

24. FUNERAL DIRECTOR: John Hafer — ADDRESS: Cumberland, Md.

RECEIVED
SEP 20 1949
BUREAU V. R.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

08428

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH
COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (In this place): MARYLAND 1HR.20MIN.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: W.VA. COUNTY: GRANT
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: DORCAS
STREET ADDRESS (If rural, give location): ✓

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
JENNIE		HINKLE	9	26	19 49

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
FEMALE	WHITE	MARRIED	FEB.25,1870	79 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	Own Home	W.VA. PETERSBURG	U.S.

13. FATHER'S NAME: ARCH CRITES
14. MOTHER'S MAIDEN NAME: CELIA WEESE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	None	HUSBAND- ED HINKLE

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
450.0 Immediate cause	(a) Cardiac Dilatation	about- 1hr. 20min
112 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cardiac asthma	several years.
	(c) Arteriosclerosis.	?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

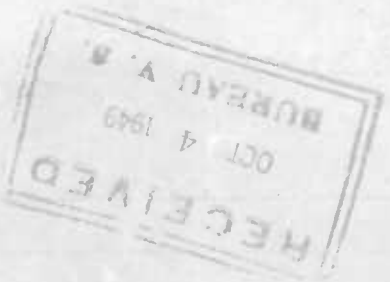
21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V. DEMING, M.D. H.V. Deming M.D.		CUMBERLAND, MARYLAND	9/26/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Sept. 28 1949	Maple Hill Cemetery	Petersburg, W. Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 26, 1949	Winter K. Hantz, M.D.	Earle Bush,	Petersburg, W. Va.


RECEIVED
OCT 4 1949
BUREAU V. A.

Dr Wolferman
18429

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place): MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eckhart
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) JOHN (Middle) ANDREW (Last) HOLSINGER

4. DATE OF DEATH: (Month) Sept. (Day) 19, (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 9-18-1895

9. AGE last birthday: 54 yrs. If under 1 year: Months, Days. If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): rubber worker

10b. KIND OF BUSINESS OR INDUSTRY: Kelly Tire Co.

11. BIRTHPLACE (State or foreign country): Eckhart, Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Holsinger

14. MOTHER'S MAIDEN NAME: Jean Stark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If year, give war or dates of service):

16. SOCIAL SECURITY NO.: 214-07-0044

17. INFORMANT: Harold Holsinger, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset and Death
20	Immediate cause	(a) Renal failure	3 days
	Antecedent cause(s)		
44 b	Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hodgkin's Disease	5 years
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1948, to Sept. 19, 1949, that I last saw the deceased alive on Sept. 18, 1949, and that death occurred at 11 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Adolph Wolferman M.D. **ADDRESS**: Frostburg **DATE SIGNED**: 9-23-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: 9-22-1949
NAME OF CEMETERY OR CREMATORY: St. Michaels Cemetery
LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG.: 9-22-49
REGISTRAR'S SIGNATURE: Mrs Nancy N. Roe

24. FUNERAL DIRECTOR: J. R. Durst, Frostburg, Md. **ADDRESS**

RECEIVED
SEP 26 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH 08430

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage — LENGTH OF STAY (In this place) 38 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First) ANTON	(Middle)	(Last) IGNATOZ	4. DATE OF DEATH	(Month) Sept. (Day) 18 (Year) 1949
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 10-2-1881	9. AGE last birthday 67 yrs.	If under 1 year Months / Days; If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) fireman	10b. KIND OF BUSINESS OR INDUSTRY Brickyard	11. BIRTHPLACE (State or foreign country) Hungary	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Michael Ignatoz	14. MOTHER'S MAIDEN NAME Betty Bolgdine				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)	16. SOCIAL SECURITY NO. 213-10-9116	17. INFORMANT AND ADDRESS Mrs. Julia Ignatoz, Mt. Savage, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause	(a) Coronary Occlusion	Immediate
Antecedent cause(s)		5 years or more
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Vascular Hypertension	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-5, 1945, to 9-15, 1949, that I last saw the deceased alive on 9-15, 1949, and that death occurred at 12:10 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
William E. Morley		Mt Savage Md.	9-18-1949

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
	9-21-49	McKeesport Pa	McKeesport	Penna

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 19-49	Veronica McDermott	J. R. Durst	Frostburg Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 21 1949
BUREAU V. S.

Evidence for change of birth date is on:

FILM No. G 122 SEP 22 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08431

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg — LENGTH OF STAY (in this place) 2 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
HOSPITAL OR INSTITUTION OR STREET ADDRESS Meyers Hospital	STREET ADDRESS (If rural, give location) 28 Park Ave

3. NAME OF DECEASED (Type or Print) (First) Caroline (Middle) (Last) Johnson

4. DATE OF DEATH (Month) 9 (Day) 11 (Year) 1949

5. SEX Female — 6. COLOR OR RACE White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed — 8. DATE OF BIRTH Oct-6-1870 — 9. AGE last birthday 78 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife — 10b. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (State or foreign country) Eckhart, Md — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Samuel C. Myers — 14. MOTHER'S MAIDEN NAME Nancy Harden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) — 16. SOCIAL SECURITY NO. None — 17. INFORMANT AND ADDRESS Ralph Johnson, 28 Park Ave Frostburg Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

450.0 Immediate cause (a) Aortic Stenosis — 4 year

Antecedent cause(s)

92a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1945, 19....., to Sept 11, 1949, that I last saw the deceased alive on Sept 11, 1949, and that death occurred at 1:00 P.m., from the causes and on the date stated above.

SIGNATURE W O McLane (Degree or title) MD — ADDRESS Frostburg Md — DATE SIGNED 9-12-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE 9-13-1949 — NAME OF CEMETERY OR CREMATORY Allegany Cemetery — LOCATION (City, town, or county) Frostburg (State) Md

DATE REC'D BY LOCAL REG. 9-14-49 — REGISTRAR'S SIGNATURE Mr. Nancy H. Roe — 24. FUNERAL DIRECTOR Jacob Hafer — ADDRESS Frostburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 20 1949
BUREAU OF S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08432

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 8 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Allegany, Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 723 Fayette Street

3. NAME OF DECEASED (Type or Print): (First) Agnes (Middle) (Last) Kelley

4. DATE OF DEATH: (Month) 9 (Day) 24 (Year) 19 49

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: June 15 1875

9. AGE last birthday: 74 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House

10b. KIND OF BUSINESS OR INDUSTRY: House

11. BIRTHPLACE (State or foreign country): Barton, Md.

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: William Kelley

14. MOTHER'S MAIDEN NAME: Rose Ann McGinnis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs. RoseAnn Frey, 723 Fayette St. (sister)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

174 **Immediate cause** (a) Adeno carcinoma of Uterus — Interval between onset and death: 2 yrs

Antecedent cause(s)

48 b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 23, 1949, to Sept. 24, 1949, that I last saw the deceased alive on Sept. 24, 1949, and that death occurred at 7 31 p.m., from the causes and on the date stated above.

SIGNATURE: Arthur F. Jones — (Degree or title): M. D. — ADDRESS: 1105 Centre St. — DATE SIGNED: Sept. 26, 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Sept 27 1949 — NAME OF CEMETERY OR CREMATORY: Philos Cemetery — LOCATION (City, town, or county) (State): Westernport, Maryland

DATE REC'D BY LOCAL REG.: Sept. 27, 1949 — REGISTRAR'S SIGNATURE: Winter K. Frantz, M.D.

24. FUNERAL DIRECTOR — ADDRESS: William H. Kight, Cumberland, Md.

RECEIVED
OCT 4 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08433

CERTIFICATE OF DEATH

Reg. Dist. No. 2

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A17

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Flintstone
LENGTH OF STAY (in this place) 12 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Route 2,

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Route 2, Flintstone
STREET ADDRESS (If rural, give location) Route 2, Flintstone

3. NAME OF DECEASED (Type or Print): (First) Herbert; (Middle); (Last) Ketterman

4. DATE OF DEATH: (Month) September (Day) 25 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: June 15 1923

9. AGE last birthday: 26 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None (Invalid)

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Bedford Pa

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Denver Ketterman

14. MOTHER'S MAIDEN NAME: Delphia Kisamore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Denver Ketterman, Route 2, Flintstone, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

353.3 Immediate cause (a) Epilepsy — Interval Between Onset and Death: Life

Antecedent cause(s)

85 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Idiocy

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 7, 1949, to Sept 25, 1949, that I last saw the deceased alive on Sept 7, 1949, and that death occurred at 5 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) J. A. Watson, M.D ADDRESS Little Orleans, Md. DATE SIGNED 9/26/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: Sept 28 1949

NAME OF CEMETERY OR CREMATORY: Oakdale Cemetery

LOCATION (City, town, or county) (State): (Near) Flintstone, Md.

DATE REC'D BY LOCAL REG. Sept 27, 1949

REGISTRAR'S SIGNATURE Nina L. Bender

24. FUNERAL DIRECTOR ADDRESS: William H. Kight, Cumberland, Md.

RECEIVED
SEP 28 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

08434

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Route 220 near — LENGTH OF STAY (in this place): 56 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Mc Coole Md. in automobile

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 524 N. Mechanic St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
Gilbert	Phillip	Kohl	Sept. 28 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	white	married	Feb. 17-1893	56 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Piano tuner	Self	Cumberland Md	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Phillip Kohl	Gertrude Bernard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT
no	[illegible]	Helen Sellers Kohl

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	about 6 yrs.
	(c)	

420 / 94a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an Autapsy* ☐, *Inspectian* ☒, *Inquiry* ☒ *thereon and from the evidence obtained by said Autapsy, Inspectian or Inquiry, find that said deceased died on the day stated above, and death in my apinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D. H. V. Deming M.D.	Cumberland Md.	9-28-1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	October 1, 1949	Greenmount Cemetery	Cumberland Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 1, 1949	[illegible]	John J. Hofer,	Cumberland, Md.

M

I

T

VS. A15A

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 5 1949
BUREAU V. S.

Within corporate limits
Dr. Simons

08435

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 730 Maryland Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 730 Maryland Ave.

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) Gertrude (Last) Kopotoes

4. DATE OF DEATH (Month) Sept. (Day) 11, (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH 10-26-1900
9. AGE last birthday 48 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Thomas, W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME John W. Turner
14. MOTHER'S MAIDEN NAME Grace B. Goff

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If year, give war or dates of service)
16. SOCIAL SECURITY NO. 219-03-8501
17. INFORMANT AND ADDRESS Mrs. Elizabeth Hopkins

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma cervix c

171 Antecedent cause(s)

48a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) generalized metastasis

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug, 1948, to Sept 11, 1949, that I last saw the deceased alive on Sept 10, 1949, and that death occurred at 12:45A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
George M Simons M.D. 128 Union St Cumberland Md

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 9-13,1949
NAME OF CEMETERY OR CREMATORY Mt. Herman
LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. Sept. 12, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR ADDRESS Charles L. George Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 20 1949
BUREAU T. S.

Dr. Gattens
08436

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Midlothian
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) JAMES (Middle) ROBERT (Last) LAYMAN

4. DATE OF DEATH (Month) Sept. (Day) 21, (Year) 1949

5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed
8. DATE OF BIRTH 5-29-1880
9. AGE last birthday 69 yrs. If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer & Boiler Fireman
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George Layman
14. MOTHER'S MAIDEN NAME Louise Crow

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)
16. SOCIAL SECURITY NO. 363-03-6176
17. INFORMANT AND ADDRESS Mrs. Venona Ware, Midlothian, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
191	Immediate cause	(a) Starvation	3 months.
45b	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma rt side face, tongue, & throat	1 yrs.
		(c) Post operative 1 yr.	1 yr.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug, 1949, to Sept 21, 1949, that I last saw the deceased alive on Sept 20, 1949, and that death occurred at 5:00 A m., from the causes and on the date stated above.

SIGNATURE W E Gattens (Degree or title) M. D. ADDRESS Frostburg, Md. DATE SIGNED 9/23/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 9-24-49
NAME OF CEMETERY OR CREMATORY Allegany Cemetery
LOCATION (City, town, or county) Frostburg, Md. (State)

DATE REC'D BY LOCAL REG. 9-23-49
REGISTRAR'S SIGNATURE Mrs. Nancy H. Roe
24. FUNERAL DIRECTOR J. R. Durst, Frostburg, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16

RECEIVED
SEP 28 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

08437

Reg. Dist. No. 6

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

T

VS. A15A

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport
MARYLAND
LENGTH OF STAY (In this place): 58 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 108 Rail-Road St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md.
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport
STREET ADDRESS (If rural, give location): 108 Rail-Road St.

3. NAME OF DECEASED (Type or Print): (First) Gracie (Middle) Mae (Last) Linkswiler

4. DATE OF DEATH: (Month) Sept (Day) 7 (Year) 19 49

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 2/14/1893

9. AGE last birthday: 56 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House-wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Albert Dayton

14. MOTHER'S MAIDEN NAME: Hattie Greenwade

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: John Linkswiler

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.2 **Immediate cause** (a) Chronic Myocarditis 6 — Interval Between Onset and Death: 6 yrs

93d **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | **19b. MAJOR FINDINGS OF OPERATION**

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | **PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY** | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H. V. Deming M.D. | (Degree or title) | ADDRESS: Cumberland, Md. | DATE SIGNED: Sept. 8, 1949

H.V. Deming

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | **DATE THEREOF**: 9/11/49 | **NAME OF CEMETERY OR CREMATORY**: Philos Cem. | **LOCATION (City, town, or county) (State)**: Westernport, Md.

DATE REC'D BY LOCAL REG.: Sept. 9/49 | **REGISTRAR'S SIGNATURE**: [illegible] Cumberland Co. Md.

24. FUNERAL DIRECTOR: E.S. Boal | **ADDRESS**: Westernport, Md.

RECEIVED
SEP 12 1949
BUREAU V. S.

Within corporate limits Burials

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 08438 4

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 1 week; HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ld Vale RD #1 Cumberland; STREET ADDRESS (If rural, give location) Cash Valley Road

3. NAME OF DECEASED (Type or Print): (First) Harrison; (Middle) Asia; (Last) Livengood

4. DATE OF DEATH: (Month) September (Day) 28 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: April 26, 1892

9. AGE last birthday: 57 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Warehouseman

10b. KIND OF BUSINESS OR INDUSTRY: Gulf Oil

11. BIRTHPLACE (State or foreign country): Salisbury, Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Harvey Livengood

14. MOTHER'S MAIDEN NAME: Caroline Newman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: 214-05-5947

17. INFORMANT AND ADDRESS: Mrs. H. A. Livengood - Ld Vale, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

570.5 Immediate cause (a) Intestinal obstruction — Interval between onset and death: 2 days

122 b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Apoplectic stroke — 1 day

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 8-26-49

19b. MAJOR FINDINGS OF OPERATION: multiple adhesions obstructing small bowel

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

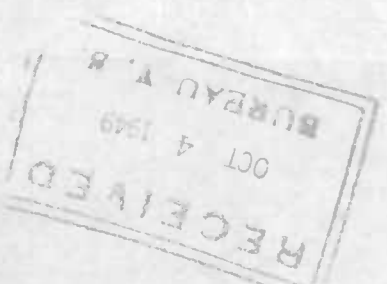
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-24-, 1949, to 9-28-, 1949, that I last saw the deceased alive on 9-28-, 1949, and that death occurred at 3 P m., from the causes and on the date stated above.

SIGNATURE: L. Wm. (Degree or title) MD ADDRESS: 57 Greene St. Cumberland Md. DATE SIGNED: 10-1-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: October 1, 1949 | NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery | LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Oct. 1, 1949 | REGISTRAR'S SIGNATURE: Walter K. Frantz, M.D. | 24. FUNERAL DIRECTOR: John J. Hafer ADDRESS: Cumberland, Md


RECEIVED
OCT 4 1949
BUREAU V. R

MARYLAND STATE DEPARTMENT OF HEALTH

6439

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg; LENGTH OF STAY (In this place): 63 yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS: 43 Grant St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg; STREET ADDRESS (If rural, give location): 43 Grant St.

3. NAME OF DECEASED (Type or Print): (First) Evan (Middle) (Last) Lloyd

4. DATE OF DEATH: (Month) Sept. (Day) 16 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married

8. DATE OF BIRTH: April 20-1886-

9. AGE last birthday: 63 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bartender

10b. KIND OF BUSINESS OR INDUSTRY: GermanBrewingCo

11. BIRTHPLACE (State or foreign country): Frostburg Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry Lloyd

14. MOTHER'S MAIDEN NAME: Margaret Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 220-16-7032

17. INFORMANT: daughter

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary occlusion	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	?
	(c)	

420.1

94a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): H.V.Deming M.D. H. V. Deming M.D. ADDRESS: Cumberland Md. DATE SIGNED: Sept.16-1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: 9-19-1949 | NAME OF CEMETERY OR CREMATORY: Allegany Cemetery | LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 9-19-49 | REGISTRAR'S SIGNATURE: Mrs. Nancy N. Rice

24. FUNERAL DIRECTOR: J. R. Durst, ADDRESS: Frostburg, Md.

RECEIVED
SEP 23 1949
BUREAU U. S.

Within corporate [illegible] DR. ENFIELD

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 08440 4

M

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland MT. SAVAGE
LENGTH OF STAY (in this place) 4 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN MT. SAVAGE
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) DOROTHY (Middle) A. (Last) LYNCH

4. DATE OF DEATH (Month) SEPT. (Day) 10 (Year) 1949

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE
8. DATE OF BIRTH JULY 14, 1933
9. AGE last birthday 16 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student
10b. KIND OF BUSINESS OR INDUSTRY School
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME LYNCH, JOSEPH
14. MOTHER'S MAIDEN NAME MARIE SWEEN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

551 Immediate cause (a) Coronary Embolism — INTERVAL BETWEEN ONSET AND DEATH few min

121 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) appendectomy

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION Sept 7 '49
19b. MAJOR FINDINGS OF OPERATION Subacute appendicitis
20. AUTOPSY? Yes ☐ No ☑

I

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 6, 1949, to Sept 10, 1949, that I last saw the deceased alive on Sept 9, 1949, and that death occurred at 6:20 a.m., from the causes and on the date stated above.

SIGNATURE S. C. Enfield (Degree or title) ADDRESS Cumberland DATE SIGNED 9/10/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Sept. 13/49
NAME OF CEMETERY OR CREMATORY St. Patricks Cemetery
LOCATION (City, town, or county) Mt. Savage (State) Md

DATE REC'D BY LOCAL REG. Sept. 11, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Elsworth S. Bond ADDRESS Westernport, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 20 1949
BUREAU V. A.

Outside City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

18441

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16

1. PLACE OF DEATH
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 220 Narrows Park Rt. 6.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland
STREET ADDRESS (If rural, give location) 220 Narrows Park Rt. 6.

3. NAME OF DECEASED (Type or Print): (First) Henry (Middle) Thomas (Last) Mattingly

4. DATE OF DEATH: (Month) Sept. (Day) 8, (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: May 2, 1877

9. AGE last birthday: 72 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Wholesaler

10b. KIND OF BUSINESS OR INDUSTRY: Meat

11. BIRTHPLACE (State or foreign country): Cooks Mills, Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James T. Mattingly

14. MOTHER'S MAIDEN NAME: Rosalia Topper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If year, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT: Mrs. Mary G. Mattingly

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

443 Immediate cause (a) Cerebral Hemorrhage R Hemiplegia — 2 mos

93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension Heart Disease — and years

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 25, 1949, to Sept 8, 1949, that I last saw the deceased alive on Sept 7, 1949, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE (Degree or title) E. Alan E. Murray M.D. ADDRESS DATE SIGNED Sept 9/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: 9-12-49 | NAME OF CEMETERY OR CREMATORY: S.S. Peter & Paul | LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG. Sept. 11, 1949 | REGISTRAR'S SIGNATURE Winter L. Fantz, M.D. | 24. FUNERAL DIRECTOR: Charles L. George | ADDRESS: Cumberland, Md.

RECEIVED
SEP 20 1949
BUREAU V. R.

Within corporate limits

08442

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 25 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 556 N. Mechanic St

3. NAME OF DECEASED (Type or Print) (First) Charles (Middle) Carl (Last) McKearn

4. DATE OF DEATH (Month) Sept (Day) 3 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Jan 1 1899
9. AGE last birthday 50 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector
10b. KIND OF BUSINESS OR INDUSTRY Fire Dept.
11. BIRTHPLACE (State or foreign country) Geneva N. J.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War I
16. SOCIAL SECURITY No. None
17. INFORMANT AND ADDRESS Mrs Helen J McKearn

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary sclerosis

420.1 Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH ?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
(CITY OR TOWN) — (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
INJURY OCCURRED While at Work ☐ Not While At work ☐ —
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 9/1, 1947 to 9/3, 1949 that I last saw the deceased alive on 9/3, 1949, and that death occurred at 8 50 p m., from the causes and on the date stated above.

SIGNATURE John K Rozman (Degree or title) M D ADDRESS Cumberland DATE SIGNED 9/5/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Sept 6 49
NAME OF CEMETERY OR CREMATORY St Marys Burial Park
LOCATION (City, town, or county) Near Cumberland (State) Md

DATE REC'D BY LOCAL REG. Sept. 5, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Louis Stein Inc. ADDRESS Cumberland Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16

RECEIVED
SEP 14 1949
BUREAU F. S.

08443

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt Savage — LENGTH OF STAY (in this place): 91 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Allegany — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt Savage
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) B (Last) Monahan
4. DATE OF DEATH: (Month) Sept (Day) 21 (Year) 1949
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: July 6 1858
9. AGE last birthday: 91 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Mt Savage Md
12. CITIZEN OF WHAT COUNTRY: USA
13. FATHER'S NAME: John Sheridan
14. MOTHER'S MAIDEN NAME: Catherine Kelly
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Anthony Monahan (Son)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage — 12 hrs

331 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis — several years

83a (c)

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1949, to Sept, 1949, that I last saw the deceased alive on Sept 9, 1949, and that death occurred at 10a m., from the causes and on the date stated above.

SIGNATURE: F. Alan G. Murray (Degree or title) — ADDRESS: Cumberland Md — DATE SIGNED: Sept 21 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Sept 23 49 — NAME OF CEMETERY OR CREMATORY: St Patricks Cem — LOCATION (City, town, or county): Mt Savage Md (State)
DATE REC'D BY LOCAL REG.: Sept 22 1949 — REGISTRAR'S SIGNATURE: Veronica McDermott
24. FUNERAL DIRECTOR: Louis Stein Inc — ADDRESS: Cumberland Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 28 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

08444

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 30 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 331 Fort Hill Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 331 Fort Hill Ave.

3. NAME OF DECEASED (Type or Print) (First) Harry (Middle) C. (Last) Morin

4. DATE OF DEATH (Month) Sept. (Day) 15 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH March18-1881
9. AGE last birthday 68 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinest helper
10b. KIND OF BUSINESS OR INDUSTRY B&O R.Ry
11. BIRTHPLACE (State or foreign country) Fairplay Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Henry Morin
14. MOTHER'S MAIDEN NAME Laura B.Amy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 705-05-4800
17. INFORMANT son) Eugene Morin

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
420.1	Immediate cause	(a) Acute cardiac failure due to	at once
94a	Antecedent cause(s) Diseases or conditinns, if any, giving rise to the above cause stating the underlying cause last	(b) coronary occlusion & coronary sclerosis	?
		(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing tn the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. H.V.Deming M.D. (Degree or title) ADDRESS Cumberland Md. DATE SIGNED Sept. 15-1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Sept 18, 1949
NAME OF CEMETERY OR CREMATORY Zion Memorial Park
LOCATION (City, town, or county) Cumberland, (State) Md.

DATE REC'D BY LOCAL REG. Sept. 18, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR John J. Hafer, ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
SEP 27 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

08445

Reg. Dist. No. 8

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing; LENGTH OF STAY (in this place) 56 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS Robin Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing; STREET ADDRESS (If rural give location) Robin Street

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Andrew	F.	Morton	Sept.	11	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Single	Sept. 23, 74	75 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Coal Miner	Coal Mine	Maryland	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Andrew Morton	Margaret Turner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
yes	World War I	None	Mrs Anna Robertson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Hepatitis & Nephritis c	
583 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 132	(b) Uremia —	
	(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cardiac Arrhythmia

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
None	None			

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 9/4/49, 19..., to 9/11, 1949, that I last saw the deceased alive on 9/11, 1949, and that death occurred at 6:30 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Paul Eugene Frye, M.D		Lonaconing Md	9/17/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Sept. 14, 49	Oak Hill Cemetery	Lonaconing, Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9/15/49	Jonnette M Boal	M. Eichhorn	Lonaconing, Md

RECEIVED
SEP 26 1949
BUREAU V. S.

Outside of City limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08446

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural near Cumberland; LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rt 2, ~~Cumberland~~ Baltimore Pike Md

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY Allegany.
CITY (If outside corporate limits, write RURAL, and give nearest town) OR TOWN Rt 2 Cumberland, Md.
STREET ADDRESS (If rural, give location) Baltimore Pike

3. NAME OF DECEASED (Type or Print): (First) Harry (Middle) (Last) Nave

4. DATE OF DEATH: (Month) Sept (Day) 18 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Feb 11, 1877

9. AGE last birthday: 72 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: General Farming

11. BIRTHPLACE (State or foreign country): Centerville, Pa

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Elza Nave

14. MOTHER'S MAIDEN NAME: Rena Savey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO. 220-10-7847

17. INFORMANT AND ADDRESS: Mrs Geo Miller, Rt 2 Cumberland Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiac Failure — Interval Between Onset and Death: 2 yrs

414 Antecedent cause(s)

92d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Rheumatic valvulitis — 20-40 yrs.

(c) Rheumatic fever — 20-40 yrs.

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis — ago.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1949, to Sept, 1949, that I last saw the deceased alive on Sept 17, 1949, and that death occurred at 12 25 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Benedict Skotarelic M.D. Rt 2 Cumberland Md.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: Sept 20, 1949 | NAME OF CEMETERY OR CREMATORY: Pleasant Grove Cemetery | LOCATION (City, town, or county): Cumberland (State): Md.

DATE REC'D BY LOCAL REG.: Sept. 20, 1949 | REGISTRAR'S SIGNATURE: Walter R. Lantz, M.D. | 24. FUNERAL DIRECTOR: John J. Hafer, Cumberland Md. ADDRESS

VS. A15

RECEIVED
SEP 27 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08447

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 60 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 731 Gephart Drive

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 731 Gephart Drive.

3. NAME OF DECEASED (Type or Print): (First) Frank (Middle) (Last) Newcomer

4. DATE OF DEATH: (Month) Sept (Day) 17 (Year) 1949

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: June 27 1858
9. AGE last birthday: 91 yrs. — If under 1 year: Months. Days — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Brewery Worker
10b. KIND OF BUSINESS OR INDUSTRY: Beer Brewery
11. BIRTHPLACE (State or foreign country): Stafford Hall Md
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: John Newcomer
14. MOTHER'S MAIDEN NAME: Ann Ridenour

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service): —
16. SOCIAL SECURITY No.: 220-03-7886
17. INFORMANT AND ADDRESS: Mrs Gwen Melown, Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

154 Immediate cause (a) Uremia — ?

Antecedent cause(s)

46d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c) Carcinoma of rectum — ?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 1, 1949, to Sept 17, 1949, that I last saw the deceased alive on Sept 17, 1949, and that death occurred at 9:10 P.m., from the causes and on the date stated above.

SIGNATURE: Samuel Jacobsen (Degree or title) — ADDRESS: 50 Pershing St — DATE SIGNED: 9/19/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Sept 20 49 — NAME OF CEMETERY OR CREMATORY: River View Cem — LOCATION (City, town, or county): Williamsport (State): Md

DATE REC'D BY LOCAL REG.: Sept. 20, 1949 — REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D. — 24. FUNERAL DIRECTOR: Louis Stein Inc — ADDRESS: Cumberland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 27 1949
BUREAU V. S.

Dr. Murray

018448

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) HENRY (Middle) (Last) NORRIS

4. DATE OF DEATH: (Month) Sept. (Day) 21 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: 2-8-1867

9. AGE last birthday: 82 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired stone mason

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Daniel Norris

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If year, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Arthur Norris, Mt. Savage, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: 2 days

83a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Artrio Sclerosis — several years

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1949, to Sept 21, 1949, that I last saw the deceased alive on Sept 21, 1949, and that death occurred at 2 P m., from the causes and on the date stated above.

SIGNATURE: J. Adam G. Brown (Degree or title) ADDRESS: Md Cumberland (Md) DATE SIGNED:

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: 9-24-49
NAME OF CEMETERY OR CREMATORY: Methodist Cemetery
LOCATION (City, town, or county) (State): Mt. Savage, Md.

DATE REC'D BY LOCAL REG.: Sept 23-49
REGISTRAR'S SIGNATURE: Vernon McDermott

24. FUNERAL DIRECTOR: J. R. Durst, Frostburg, Md. ADDRESS:

VS. A15

RECEIVED
SEP 26 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

68449

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age if it is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 50 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 173 S Allegany St.

3. NAME OF DECEASED (Type or Print): (First) Phoebe (Middle) Ann (Last) Oliver

4. DATE OF DEATH: (Month) 9 (Day) 16 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Oct 24 1857

9. AGE last birthday: 91 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: John Brooke

14. MOTHER'S MAIDEN NAME: Mary Gregory

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Edward Oliver - son

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Septicemia	6 wks
715 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Extensive decubitous ulcers	6 wks
153	(c) Senility	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 30, 1949, to Sept. 16, 1949, that I last saw the deceased alive on Sept 16, 1949, and that death occurred at 1 20 p m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones	M.D.	110 S. Centre St.	Sept. 17, 1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Sept 19 49	Rose Hill Cem	Cumberland Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 19, 1949	Hunter R Beatty, M.D.	Louis Stein	Cumberland

VS. A15

RECEIVED
SEP 27 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

08450

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 6 1/2 hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: W.Va. COUNTY: Mineral
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ridgely
STREET ADDRESS (If rural, give location): 18 John St. ✓

3. NAME OF DECEASED (Type or Print): (First) Juanita (Middle) Gail (Last) Phillips

4. DATE OF DEATH: (Month) Sept. (Day) 5 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: Feb. 12-1949

9. AGE last birthday: 0 yrs. If under 1 year: Months 6, Days 23; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ---

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Hamilton W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Herman R. Phillips

14. MOTHER'S MAIDEN NAME: Elsie Foster

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Allegany Hospital records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Dehydration due to diarrhoea	about 5
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Malnutrition	days
	(c) Intussusception	

5700
122b

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: ---

19b. MAJOR FINDINGS OF OPERATION: ---

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: ---

(CITY OR TOWN) (COUNTY) (STATE): ---

TIME OF INJURY (Month) (Day) (Year) (Hour): ---

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR? ---

22. *I certify that I took charge of the remains described above, held an Autopsy* ☒, *Inspection* ☒, *Inquiry* ☒ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE (Degree or title): H.V. Deming M.D. H.V. Deming M.D.

ADDRESS: Cumberland Md.

DATE SIGNED: Sept. 5-1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: 9/7/49

NAME OF CEMETERY OR CREMATORY: Mon Memorial

LOCATION (City, town, or county) (State): Cumberland. Md.

DATE REC'D BY LOCAL REG.: Sept. 6, 1949

REGISTRAR'S SIGNATURE: W.R. Frantz, M.D.

24. FUNERAL DIRECTOR: H. Wayne George

ADDRESS: Cumb. Md.

RECEIVED
SEP 14 1949
BUREAU T. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08451

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

T

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 35 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 59 Offutt St.

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) C (Last) Rankin

4. DATE OF DEATH: (Month) 9/ (Day) 29 (Year) 1949

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M

8. DATE OF BIRTH: Jan. 4, 1886

9. AGE last birthday: 63 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: USA.

13. FATHER'S NAME: Thomas Furlow

14. MOTHER'S MAIDEN NAME: Jennie Rice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Jesse W. & John D. Rankin (sons)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

434.3 Immediate cause (a) Cardiac decompensation — Interval Between Onset and Death: 2 Days

Antecedent cause(s)

95C Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 21, 1949, to Sept. 29, 1949, that I last saw the deceased alive on Sept. 28, 1949, and that death occurred at 9:00 a.m., from the causes and on the date stated above.

SIGNATURE: Arthur F. Jones — (Degree or title): M.D. — ADDRESS: 110 S. Centre St. — DATE SIGNED: Sept. 30, 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Oct. 2, 1949 — NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Oct. 1, 1949 — REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR — ADDRESS: William H. Kight, Cumberland, Md.

RECEIVED
OCT 4 1949
BUREAU V. S.

Within corporate limits

Dr. Brings.

08452

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Harford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Aberdeen
HOSPITAL OR INSTITUTION OR STREET ADDRESS 22 Greene St.,	STREET ADDRESS (If rural, give location) Osborn Road

3. NAME OF DECEASED (Type or Print)	(First) NELDA	(Middle) CATHERINE	(Last) REPHANN	4. DATE OF DEATH	(Month) Sept. (Day) 3, (Year) 1949
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 2-26-1917	9. AGE last birthday 32 yrs.	If under 1 year Months / Days; If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Randolph Co. W. Va.	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Luther W. Kerns	14. MOTHER'S MAIDEN NAME Zoey Warner				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY No. 214-05-5533	17. INFORMANT Lee E. Rephann			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
416	Immediate cause	(a) Congestive heart failure	2 weeks
95b	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) rheumatic heart	2 years
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 9-2-, 19 7, to 9-3, 1949, that I last saw the deceased alive on 9-2-, 1949, and that death occurred at 4 30A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
L Brings	MD	59 Greene St	9-3-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	9-5-49	Eckhart Cem.	Eckhart, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 5, 1949	Winter R. Frantz, M.D.	H. Wayne George	Cumberland Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

L Briggs

RECEIVED
SEP 14 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08453

Dr. J H Wolverton

CERTIFICATE OF DEATH

Reg. Dist. No. 6

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

T

VS. A15

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport; LENGTH OF STAY (in this place): 28 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS: 211 Maryland Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport; STREET ADDRESS (If rural, give location): ~~Westernport~~ 211 Maryland Ave

3. NAME OF DECEASED (Type or Print): ~~Susan~~ Elizabeth Susan Riggleman

4. DATE OF DEATH: Sept 24 19 49

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: March 31, 1900

9. AGE last birthday: 49 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Frostburg, Maryland

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Alfred Rizer

14. MOTHER'S MAIDEN NAME: Lucy Pope

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Register Riggleman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) Coronary Occlusion. — Interval Between Onset and Death: 6mo

94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Myocardial Degeneration, — 6yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 15 19 49 to Sept 24 19 49 that I last saw the deceased alive on Sep 23, 1949, and that death occurred at 9.30 am., from the causes and on the date stated above.

SIGNATURE (Degree or title): James M Slusher MD — ADDRESS: Piedmont W Va — DATE SIGNED: 9/26/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Sept 27, 1949 — NAME OF CEMETERY OR CREMATORY: Philos Cemetery — LOCATION (City, town, or county) (State): Westernport, Allegany, Md.

DATE REC'D BY LOCAL REG.: 9/27/49 — REGISTRAR'S SIGNATURE: Raymond Baker MD

24. FUNERAL DIRECTOR: Ellsworth S. Boal — ADDRESS: Westernport, Md.

RECEIVED
SEP 29 1949
BUREAU F. S.

Within corporate limits DR. REES

08454

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, LENGTH OF STAY (in this place) 10 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location) 450 N. MECHANIC STREET

3. NAME OF DECEASED (Type or Print) (First) RICHARD (Middle) (Last) ROWE (ROWE			4. DATE OF DEATH (Month) SEPT. (Day) 18, (Year) 1949		
5. SEX MALE	6. COLOR OR RACE COLORED	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH SEPT. 1, 1913	9. AGE last birthday 36 yrs.	If under 1 year Months / Days; If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PORTER	10b. KIND OF BUSINESS OR INDUSTRY BUS STATION	11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME — Unknown		14. MOTHER'S MAIDEN NAME —			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W. W. II	16. SOCIAL SECURITY No. 232-26-3065	17. INFORMANT MARY SMITH ROWE (wife)			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Peritonitis	4 Hrs
570.5 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Intestinal Obstruction	Unknown
122b	(c) Adhesion abdomen	Unknown

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Sept 14, 1949, to Sept 18 1949, that I last saw the deceased alive on Sept 18, 1949, and that death occurred at 15:40 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
[signature]	[signature]	404 Decatur St Cumberland	Sept 19 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Sept 20, 49	NAME OF CEMETERY OR CREMATORY Moorefield Cem	LOCATION (City, town, or county) Moorefield	(State) W. Va
DATE REC'D BY LOCAL REG. Sept. 20, 1949	REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR Louis Stein Inc.	ADDRESS Cumberland	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 27 1949
BUREAU V. S.

Within corporate limits

Dr. Whitworth

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

08455

Reg. Dist. No. 4

Phone 1454

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY Allegany Cumberland MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (in this place) 18 days HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital	2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Garrett CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Oakland STREET ADDRESS (If rural, give location) R. F. D. #1 ✓

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
HELEN	JEAN	RUMER	Sept	19	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Female	White	Single	8/21/1949	[redacted] yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Oakland, Md. Route #1	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Dorsey Rumer	Emma Nair.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	None	Dorsey Rumer, Oakland, Md. Rd 1

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

751 Immediate cause (a) 1. Meningitis - Secondary to (2) below.

157a Antecedent cause(s) 2. Spina Bifida - Severe.

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) 3. Hydrocephalus

(c) 4. Bilateral Club Feet.

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 2 Sept., 1949, to 18 Sept., 1949, that I last saw the deceased alive on 18 Sept., 1949, and that death occurred at 2 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Fullerton Whitworth M.D.	Cumberland Md	19 Sept 49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	9/21st/1949	Oakland Cemetery	Oakland, Maryland.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 21, 1949	Wintes R. Frantz, M.D.	Emroy D. Bolden	Oakland Md

VS. 115

RECEIVED
SEP 27 1949
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

08456

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: near Cumberland — LENGTH OF STAY (in this place): In ambulance
HOSPITAL OR INSTITUTION OR STREET ADDRESS: in route to - Memorial Hospital — in Ambulance

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md — COUNTY: Garrett
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: P.O. Accident (rural)
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
James	Clark	Rush	Sept	6	19 49

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	white	married	Aug. 9-1896	53 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer		Accident Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Clark Rush	Mary Humbertson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	None	Wife) Margaret A.F.Rush

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
331 **Immediate cause**	(a) Cerebral hemorrhage (apoplexy-)	4 hours
83a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H.V. Deming M.D.	Cumberland Md	Sept. 6-1949

23. BURIAL, CREMATION OR REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Sept. 9 49	Bloomington Rose Cem.	Mey Friendsville Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 6, 1949	M.R. Lantz M.D.	Herbert C. Leighton	Oakland Md

VS. A15A

RECEIVED
SEP 14 1949
BUREAU V. B.

Within corporate limits
Evidence for addition of #8,14,23 shown on:

FILM No. G 122 OCT 4 1949

08457

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE Maryland
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (In this place) 70 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 N. Liberty St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 671 St Mary's Ave

3. NAME OF DECEASED (Type or Print): (First) Max (Middle) [illegible] (Last) Schmier

4. DATE OF DEATH: (Month) Sept (Day) 19 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (write): Married

8. DATE OF BIRTH: [illegible]

9. AGE last birthday: 60 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber.

10b. KIND OF BUSINESS OR INDUSTRY: Own Shop

11. BIRTHPLACE (State or foreign country): Austria

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry Schmier

14. MOTHER'S MAIDEN NAME: [illegible] Hilda Mantel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT: Sadie Rinehuemer Schmier (wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Thrombosis — 1/2 hour

420.1

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
94a (b) Coronary Artery Disease — 1942
(c) Hypertensive Disease — 1942

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/21, 1949, to 9/19, 1949, that I last saw the deceased alive on 9/19, 1949, and that death occurred at 4.20 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Samuel Jacobson MD — ADDRESS: 50 Bishop St. Cumberland Md — DATE SIGNED: 9/20/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial & Removal — DATE THEREOF: Sept 22 49 — NAME OF CEMETERY OR CREMATORY: Wildwood Cemetery — LOCATION (City, town, or county) (State): New York City, New York

DATE REC'D BY LOCAL REG.: Sept. 20, 1949 — REGISTRAR'S SIGNATURE: Winter R. Hartz, M.D. — 24. FUNERAL DIRECTOR / ADDRESS: Louis Stein Inc. Cumberland Md

RECEIVED
SEP 27 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08458

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Allegany — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) 56 Spring St

3. NAME OF DECEASED (Type or Print): (First) Baby (Middle) (Last) Schurg

4. DATE OF DEATH: (Month) Sept (Day) 30 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Infant

8. DATE OF BIRTH: Sept 29 1949

9. AGE last birthday: ____ yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours 1 Min. 28

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Frostburg Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Carl Schurg

14. MOTHER'S MAIDEN NAME: Shirley Carter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Shirley C Schurg

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

776 **Immediate cause** (a) Prematurely 28 weeks

159 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 29, 1949, to Sept 30, 1949, that I last saw the deceased alive on Sept 29, 1949, and that death occurred at 1:23 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

W O McClane MD Frostburg Md Sept 30-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE 9-30-49 — NAME OF CEMETERY OR CREMATORY Eckhart Cemetery — LOCATION (City, town, or county) (State) Eckhart, Md.

DATE REC'D BY LOCAL REG. 9-30-49 — REGISTRAR'S SIGNATURE Mrs Nancy A Roe

24. FUNERAL DIRECTOR ADDRESS Carl Schurg 56 Spring St. Frostburg Md.

VS. A15

RECEIVED
OCT 6 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

08459

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND 31 yrs
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) H. 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 402 N.Center St.

3. NAME OF DECEASED (Type or Print) (First) Peter (Middle) Joseph (Last) Schultz
4. DATE OF DEATH (Month) Sept. (Day) 15 (Year) 1949
5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH Sept.28-1895
9. AGE last birthday 54 yrs. — If under 1 year Months / Days — If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipefitter helper
10b. KIND OF BUSINESS OR INDUSTRY B&O R.Ry
11. BIRTHPLACE (State or foreign country) Brooklyn N.Y.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Schultz
14. MOTHER'S MAIDEN NAME Francis Schuman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W. 1
16. SOCIAL SECURITY No. 214-07-0263
17. INFORMANT wife) Hazel P. Schultz

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 Immediate cause (a) Cardiac Failure due to — 1 day

95c Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cardiac hypertrophy (marked) and coronary — ?

(c) Sclerosis

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. operation for gastric ulcers in 1939 Partial intestinal obstruction due to an

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. H.V. Deming M.D. (Degree or title) ADDRESS Cumberland Md. DATE SIGNED Sept. 15-1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE THEREOF Sept 18 49 — NAME OF CEMETERY OR CREMATORY Hillcrest Cem — LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. Sept. 16, 1949 — REGISTRAR'S SIGNATURE Winter R. Lantz, M.D. — 24. FUNERAL DIRECTOR Louis Stein Inc — ADDRESS Cumberland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
SEP 20 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

08460

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 79
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 506 Woodside Ave

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 506 Woodside Ave.

3. NAME OF DECEASED (Type or Print): (First) Michael (Middle) L. (Last) Shea

4. DATE OF DEATH: (Month) Sept. (Day) 22 (Year) 19 49

5. SEX: Male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widower

8. DATE OF BIRTH: April 29-1870

9. AGE last birthday: 79 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Car builder

10b. KIND OF BUSINESS OR INDUSTRY: B&O.R.Ry

11. BIRTHPLACE (State or foreign country): Frostburg Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Michael Shea

14. MOTHER'S MAIDEN NAME: Catherine Powers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 705-09-9654

17. INFORMANT: William D.Shea

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause (a)	Coronary occlusion	at once
Antecedent cause(s) Diseases or conditinns, if any, giving rise to the above cause stating the underlying cause last (b)	Coronary sclerosis	?
(c)		

420.1
94a

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

H.V.Deming M.D. H.V. Deming M.D. Cumberland Md. Sept. 22- 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: 9/24/49 | NAME OF CEMETERY OR CREMATORY: St. Michaels | LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG.: Sept 24, 1949 | REGISTRAR'S SIGNATURE: Winter K. Hantz, M.D. | 24. FUNERAL DIRECTOR: H. Wayne George | ADDRESS: Cumberland, Md

RECEIVED
SEP 27 1949
BUREAU V. S.

Outside of City Limits

08461

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN near Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS (route220) ambulance, in-route to Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport
STREET ADDRESS (If rural, give location) Main St. Extended

3. NAME OF DECEASED (Type or Print) (First) Jasper (Middle) Allen (Last) Smith
4. DATE OF DEATH (Month) Sept. (Day) 6 (Year) 1949
5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower
8. DATE OF BIRTH June 13-1897
9. AGE last birthday 52 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - Retired
10b. KIND OF BUSINESS OR INDUSTRY W.P.A.
11. BIRTHPLACE (State or foreign country) Doversville Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles J. Smith
14. MOTHER'S MAIDEN NAME Annie R. Whetzel
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Memorial Hospital record

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

584 Immediate cause (a) Acute Pancreatitis

126 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Acute Cholecystitis

(c) Cholelithiases

INTERVAL BETWEEN ONSET AND DEATH about 3 weeks

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V. Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED Sept. 6-1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Sept. 8, 1949
NAME OF CEMETERY OR CREMATORY Philos Cemetery
LOCATION (City, town, or county) (State) Westernport, Maryland
DATE REC'D BY LOCAL REG. Sept. 6, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz M.D.
24. FUNERAL DIRECTOR Boals Funeral Home, ADDRESS " "

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
SEP 14 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08462

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 50 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 417 Arch St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 417 Arch St.

3. NAME OF DECEASED (Type or Print): (First) Reginald (Middle) (Last) Stallings

4. DATE OF DEATH: (Month) Sept. (Day) 18 (Year) 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
M	W	Married	July 19, 1880	69 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Odd Jobs (Labor)
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Oldtown, Md.
12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service):
16. SOCIAL SECURITY NO.: 213-18-2962
17. INFORMANT AND ADDRESS: Wife: Maisey Stalling 417 Arch St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

151 **Immediate cause** (a) Cardiac failure — Interval between onset and death: 4 hrs.

46b **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Carcinoma of Stomach

(c) ? metastasis — 2 yr.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 18, 1949, to same, 19....., that I last saw the deceased alive on Sept 18, 1949, and that death occurred at 12:45 A m., from the causes and on the date stated above.

SIGNATURE: John A. Dyer, M.D. (Degree or title) — ADDRESS: 247 Virginia ave — DATE SIGNED: 9-19-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	9/20/49	Rose Hill Cem	Cumberland, Md.

DATE REC'D BY LOCAL REG.: Sept. 19, 1949 — REGISTRAR'S SIGNATURE: Minister R. Frantz, M.D.
24. FUNERAL DIRECTOR: James F. Scarpelli — ADDRESS: Cumberland, Md.

VS. A15

RECEIVED
SEP 27 1949
BUREAU V. S.

Within corporate limits

08463

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 3 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): Washington St.

3. NAME OF DECEASED (Type or Print): (First) Agnes (Middle) (Last) Stewart

4. DATE OF DEATH: (Month) 9 (Day) 9 (Year) 1949

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: Dec. 15, 1872

9. AGE last birthday: 76 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Stewart

14. MOTHER'S MAIDEN NAME: Mary Watson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service):

16. SOCIAL SECURITY NO.: -------

17. INFORMANT: John Stewart

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocardial Failure	3 wks
Antecedent cause(s)		
422.2 / 93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Myocarditis	1½ yrs
	(c) Senility	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec., 1946, to Sept. 9, 1949, that I last saw the deceased alive on Sept 7, 1949, and that death occurred at 3:35 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Arthur F. Jones M.D. — ADDRESS: 110 S. Centre St. — DATE SIGNED: Sept. 9, 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 9/11/49 — NAME OF CEMETERY OR CREMATORY: Allegany Cemetery — LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG.: Sept. 14, 1949 — REGISTRAR'S SIGNATURE: Winter K. Hantz, M.D.

24. FUNERAL DIRECTOR: J. R. Durst, Frostburg, Md. — ADDRESS:

RECEIVED
SEP 20 1949
BUREAU V. R.

Outside of City Limits

Dr. Brings

08464

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. # 2, Williams Rd	STREET ADDRESS (If rural, give location) R.D. # 2, Williams Road

3. NAME OF DECEASED (Type or Print) (First) John (Middle) T. (Last) Stewart

4. DATE OF DEATH (Month) Sept. (Day) 14, (Year) 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Male	White	Widowed	4-5-1862	87 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer		Polish Mt., Maryland	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Stewart	Rebecca ----------.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No		None	Mrs. Shay Wigfield

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause	(a) Congestive heart failure	2 weeks
94a Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) acute coronary occlusion	2 weeks
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Sept 13, 1949, to Sept 14, 1949, that I last saw the deceased alive on Sept 13, 1949, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
L. Brings	(MD)	59 Greene St.	9-15-49

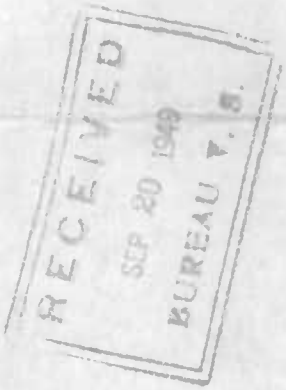
23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	9-16-1949	Mt. Herman Cem.	Near Cumberland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 16, 1949	Winter R. Frantz, M.D.	Charles L. George	Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15


RECEIVED
SEP 20 1949
BUREAU V. S.

Within corporate limits

08465

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland (rural); LENGTH OF STAY (In this place): 5 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: (rural) Cumberland
STREET ADDRESS (If rural, give location): R.F.D.3 Bedford Road.

3. NAME OF DECEASED (Type or Print): (First) Paul (Middle) Leon (Last) Sullivan
4. DATE OF DEATH: (Month) Sept. (Day) 19 (Year) 1949
5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married
8. DATE OF BIRTH: Nov. 19-1902
9. AGE last birthday: 46 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician
10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.
11. BIRTHPLACE (State or foreign country): Westernport Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Patrick Sullivan
14. MOTHER'S MAIDEN NAME: Elizabeth Guy
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-074-112
17. INFORMANT: hospital record

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Intracranial hemorrhage due to a fracture	6 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) of the skull.	
	(c) also had meningitis	

983
168

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.): 2 Bedford st. (CITY OR TOWN): Cumberland (COUNTY): Allegany (STATE): Md.
TIME OF INJURY (Month) (Day) Sept.13/49 (Year) (Hour) 12-45 A m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Quarrel-fist fight, head hit sidewalk

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.*

SIGNATURE (Degree or title): H.V.Deming M.D. H.V. Deming M.D. ADDRESS: Cumberland Md. DATE SIGNED: Sept. 19-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: 9-21-49 | NAME OF CEMETERY OR CREMATORY: Johnson's Cemetery | LOCATION (City, town, or county) (State): Frostburg, Md. Garrett County

DATE REC'D BY LOCAL REG.: Sept. 21, 1949 | REGISTRAR'S SIGNATURE: Wintie L. Hartz, M.D.

24. FUNERAL DIRECTOR: John J. Hafer ADDRESS: Cumberland, Md.

RECEIVED
SEP 27 1949
BUREAU V. S.

Within corporate limits

08466

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 23 Potomac St.,

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
STREET ADDRESS (If rural, give location) 23 Potomac St.,

3. NAME OF DECEASED (Type or Print) (First) ETHEL (Middle) MINERVA (Last) TAYLOR

4. DATE OF DEATH (Month) (Day) (Year) Sept. 9, 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 5/31/1879
9. AGE last birthday 70 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Greenspring, W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Joseph E. Light
14. MOTHER'S MAIDEN NAME Lauranda J. McLaughlin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Joseph F. Taylor

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Thrombosis — Sudden

420.1 Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1946, to Sept. 9, 1949, that I last saw the deceased alive on Sept. 8, 1949, and that death occurred at 7 am m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Clay J. Lunett M.D. ADDRESS Cumberland DATE SIGNED 9/9/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Sept. 11, 1949
NAME OF CEMETERY OR CREMATORY Hillcrest Cem.
LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. Sept. 11, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR H. Wayne George ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 20 1949
BUREAU V. A.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08467

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (In this place) 30 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1316 Virginia Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 1316 Virginia Ave.

3. NAME OF DECEASED (Type or Print) (First) Tishia (Middle) Mae (Last) Teets

4. DATE OF DEATH (Month) Sept. (Day) 17 (Year) 1949

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH April 18, 1886

9. AGE last birthday 63 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook

10b. KIND OF BUSINESS OR INDUSTRY Y. W. C. A.

11. BIRTHPLACE (State or foreign country) Friendsville, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Fearer

14. MOTHER'S MAIDEN NAME Lucinda Shroyer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT AND ADDRESS Chancy Teets, 1313 Va. Ave. Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiac failure

170 Antecedent cause(s)

50 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma Breast

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/ 1 7, 19 4 9, to 9/ 1 7, 19 4 9, that I last saw the deceased alive on D.O.A., 19..., and that death occurred at 7 0 0 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

George M. Brown M.D. Cumberland md. 9/19/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE Sept. 20, 1949

NAME OF CEMETERY OR CREMATORY Hill Crest Burial Park

LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. Sept. 20, 1949

REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.

24. FUNERAL DIRECTOR William H. Kight ADDRESS Cumberland, Md.

VS-A13

RECEIVED
SEP 27 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08468

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 415 South St.

3. NAME OF DECEASED (Type or Print): (First) Joseph (Middle) Carl (Last) Thomas Sr.

4. DATE OF DEATH: (Month) Sept. (Day) 11 (Year) 1949

5. SEX: MALE

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: Nov. 20. 1895

9. AGE last birthday: 53 yrs.
If under 1 year: Months 9 Days 21
If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Home Appliance Corp.

11. BIRTHPLACE (State or foreign country): Wheeling, W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Joseph Thomas

14. MOTHER'S MAIDEN NAME: Lottie Goss

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-05-9017

17. INFORMANT: Wife - Maud Thomas

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset and Death
420.0	Immediate cause	(a) Myocardial Insufficiency	12 hours
61	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Myocardial Infarctions	3 wks
		(c) Coronary Sclerosis (Severe) Arteriosclerotic heart disease	?
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Diabetes mellitus	3 yrs

19a. DATE OF OPERATION: No

19b. MAJOR FINDINGS OF OPERATION: No

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): No

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): No (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): No m.

INJURY OCCURRED While at Work ☐ Not While At work ☐ No

HOW DID INJURY OCCUR? No

22. I hereby certify that I attended the deceased from 5 Aug, 1949, to 11 Sep, 1949, that I last saw the deceased alive on 10 Sep, 1949, and that death occurred at 11:25 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Howell A Wiseman MD 112 Bedford St Cumberland, Md Sept 11 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: Sept. 14 1949

NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

LOCATION (City, town, or county) (State): Cumberland Md.

DATE REC'D BY LOCAL REG.: Sept. 13, 1949

REGISTRAR'S SIGNATURE: Walter R. Frantz, M.D.

24. FUNERAL DIRECTOR: Louis Stein Inc

ADDRESS: Cumberland, Md.

RECEIVED
SEP 20 1949
BUREAU V. S.

Within corporate limits

08469

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 4 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): Frank Avenue Extended

3. NAME OF DECEASED (Type or Print): (First) Sarah (Middle) (Last) Turner

4. DATE OF DEATH: (Month) 9 (Day) 21 (Year) 19 49

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Aug. 11, 1866

9. AGE last birthday: 83 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Dalton, Scotland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Turner

14. MOTHER'S MAIDEN NAME: Flora Grey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. George McLuckie

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

292.4 **Immediate cause** (a) Chronic Aplastic Anemia — 1 yr

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

732 (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec., 1946, to Sept. 21, 1949, that I last saw the deceased alive on Sept. 20, 1949, and that death occurred at 12 50 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

Arthur F. Jones Jr. M.D. — 110 S Centre St. — Sept. 22, 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Sept. 23, 1949 — NAME OF CEMETERY OR CREMATORY: Allegany Cemetery — LOCATION (City, town, or county) (State): Frostburg, Maryland

DATE REC'D BY LOCAL REG.: Sept. 22, 1949 — REGISTRAR'S SIGNATURE: Walter R. Franz M.D. — 24. FUNERAL DIRECTOR — ADDRESS: Jacob Taper, Frostburg, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 27 1949
BUREAU V. B.

Evidence for change in birth date is on:

FILM No. G 122 SEP 22 1949

08470

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg — LENGTH OF STAY (in this place) Lifetime	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
HOSPITAL OR INSTITUTION OR STREET ADDRESS 88 Ormond St	STREET ADDRESS 88 (If rural, give location) Ormond

3. NAME OF DECEASED (Type or Print)	(First) Lillie	(Middle) (Lillie)	(Last) Wade	4. DATE OF DEATH	(Month) 9	(Day) 11	(Year) 1949
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Oct. 26 1868	9. AGE last birthday 80 yrs.	If under 1 year Months.	Days	If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Frostburg, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Anthony Gerlach		14. MOTHER'S MAIDEN NAME Henrietta Conrad	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT AND ADDRESS Mrs George Kerns, 241 Walsh Hill Frostburg, Md.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

384 Immediate cause (a) Cerebral Arteriosclerosis — Several years

85 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cerebral Arteriosclerotic Epilepsy — Several years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1947, 19....., to Sept 11, 1949, that I last saw the deceased alive on Sept 9, 1949, and that death occurred at 1:30 A.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W. M. Lane	MD	Frostburg Md	9-12-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 9-14-1949	NAME OF CEMETERY OR CREMATORY Allegany Cem.	LOCATION (City, town, or county) Frostburg	(State) Md.
DATE REC'D BY LOCAL REG. 9-14-49	REGISTRAR'S SIGNATURE Mrs. Nancy H. Rose	24. FUNERAL DIRECTOR Jacob Hafer	ADDRESS Frostburg Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 20 1949
BUREAU T. S.

Within corporate limits

Evidence for addition of 18c shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08471

FILM No. G 122 OCT 24 1949

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH — COUNTY: Allegany — STATE: MARYLAND — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland, Md. — LENGTH OF STAY (in this place): — HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Lonaconing — STREET ADDRESS (If rural, give location): [redacted]

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Moses	William	Walters	9	6	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Widowed	4-24-1872	77 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Miner - Retired	Coal Mines	Carlos Junction Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Walters	Susan Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	None	Thos. J. & John Walters (Sons)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocardial Failure	12 days
334 Antecedent cause(s) 97 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Senility	6 yrs
	(c) Evidence of cerebral & general arteriosclerosis. (10/24/49 a.g.)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Dec., 1946, to Sept. 6, 1949, that I last saw the deceased alive on Sept. 4, 1949, and that death occurred at 12 36 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones M.D.		110 S. Centre St.	Sept. 6, 1949

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	9-9-49	Oak Hill Cem.	Lonaconing, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9-7-49	Walter L. Frantz, M.D.	George Eichhorn	Lonaconing, Md.

RECEIVED
SEP 14 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

08472

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

VS. A15A

1. PLACE OF DEATH
COUNTY: Allegany
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 30 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: rear-107 Offutt St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md.
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): rear-107 Offutt St.

3. NAME OF DECEASED (Type or Print): (First) George (Middle) (Last) Welsh

4. DATE OF DEATH: (Month) Sept. (Day) 24 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Feb. 16-1870

9. AGE last birthday: 79 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Boilermaker helper

10b. KIND OF BUSINESS OR INDUSTRY: B&O.R.Ry

11. BIRTHPLACE (State or foreign country): Clariton Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unable to state

14. MOTHER'S MAIDEN NAME: Unable to state

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 705-05-5273

17. INFORMANT: Mildred Welsh

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
334 Immediate cause	(a) Coronary occlusion	at once
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerotic heart disease due to coronary sclerosis.	several years.
	(c) Apoplexy	6 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

H.V.Deming M.D. H.V. Deming M.D. Cumberland Md. Sept. 24-1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: Sept. 27, 1949 | NAME OF CEMETERY OR CREMATORY: Mt. Summit Methodist | LOCATION (City, town, or county) (State): Mt. Summit, Md.

DATE REC'D BY LOCAL REG.: Sept. 27, 1949 | REGISTRAR'S SIGNATURE: Wintes R. Frantz, M.D. | 24. FUNERAL DIRECTOR: John J. Hafer | ADDRESS: Cumberland, Md.

RECEIVED
OCT 4 1949
BUREAU F. S.

Within corporate limits DR. MIRKIN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08473

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (In this place) 39 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Pennsylvania COUNTY Bedford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Breezewood
STREET ADDRESS (If rural, give location) RT #1

3. NAME OF DECEASED (Type or Print) (First) BERTHA (Middle) Rachel Winck (Last) [redacted]

4. DATE OF DEATH (Month) (Day) (Year) SEPT. 7 1949

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED
8. DATE OF BIRTH AUG 25 1883
9. AGE last birthday 66 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Bedford County, Penna.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME [redacted] Nelson Williams
14. MOTHER'S MAIDEN NAME [redacted] Sarah Ellen Morgart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Shoemaker Funeral Home

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset and Death
170	Immediate cause	(a) Carcinomatosis, generalized	8-10 mo.
50	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) due to Carcinoma Rt Breast	3 yrs.
		(c) Fract. pathol. left femur	6 wks.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION none
19b. MAJOR FINDINGS OF OPERATION none
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) X
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED ~~While at~~ Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Aug 1, 1949, to Sept 7, 1949, that I last saw the deceased alive on Sept 6, 1949, and that death occurred at 7 15 a.m., from the causes and on the date stated above.

SIGNATURE A. J. Mirkin (Degree or title) M.D. ADDRESS 115 So. Centre St DATE SIGNED 9/7/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Sept. 9, 1949
NAME OF CEMETERY OR CREMATORY Union Memorial Cem
LOCATION (City, town, or county) (State) Near Everett, Penna.

DATE REC'D BY LOCAL REG. Sept. 7, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz M.D.
24. FUNERAL DIRECTOR Richard R. Shoemaker ADDRESS Everett, Penna.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
SEP 14 1949
BUREAU V. S.

Dr. J. H. Wolverton, Jr.
08474

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Barton — LENGTH OF STAY (in this place) 33 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Barton
HOSPITAL OR INSTITUTION OR STREET ADDRESS - - - - - - -	STREET ADDRESS (If rural give location) - - - - - - - -

3. NAME OF DECEASED (Type or Print) (First) Elsie	(Middle) Florence	(Last) Winters	4. DATE OF DEATH (Month) September	(Day) 12	(Year) 1949
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH Sept 7, 1891	9. AGE last birthday 58 yrs.	If under 1 year Months / Days; If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY - - -	11. BIRTHPLACE (State or foreign country) Garrett Co., Md.	12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME Charles F. Broadwater		14. MOTHER'S MAIDEN NAME Lenie F. Duckworth			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT Mr. Roy Winters			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
153 Immediate cause	(a) Carcinoma of Tumor Colon	2 yrs
46e Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) Carcinoma Fossa	6 mo

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1949, to Apr 1949, that I last saw the deceased alive on Sept 11, 1949, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

James H. Wolverton Resident Wis 9/13 49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Sept 14 1949	NAME OF CEMETERY OR CREMATORY North Glade Cemetery	LOCATION (City, town, or county) (State) Garrett Co., Md.
DATE REC'D BY LOCAL REG. Sept. 14/49	REGISTRAR'S SIGNATURE [illegible]	24. FUNERAL DIRECTOR Ellsworth S. Boal, Westernport, Md.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 16 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08475

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; MARYLAND; LENGTH OF STAY (in this place) 1 year; HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md.; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Vale Summit; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Lucinda (Last) Winters

4. DATE OF DEATH: (Month) 9 (Day) 1 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Dec. 26-1854

9. AGE last birthday: 94 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Corriganville, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Burkett

14. MOTHER'S MAIDEN NAME: Mary Mathews

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Mrs Wm. Leake, Vale Summit, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Toxic Myocarditis	5 d.
903.0 Antecedent cause(s)	(1) Acute Parotitis	5 d.
186a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) (2) Avitaminosis, Malnutrition, Dehydration	8 - 12 d.
	(c) (3) Comminuted fractures of neck + greater Trochanter, R femur	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertension 28 d.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident

PLACE (Home, farm, factory, street, office bldg., etc.): Home

(CITY OR TOWN) (COUNTY) (STATE): Vale Summit, Allegany, Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): 8, 4, 49, 38 m.

INJURY OCCURRED While at Work ☒ Not While At work ☐

HOW DID INJURY OCCUR? Fall, (giddy) in dining room.

22. I hereby certify that I attended the deceased from 8/5, 1949, to 9/1, 1949, that I last saw the deceased alive on 9/1, 1949, and that death occurred at 4.20 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Frank T. Harnett MD

ADDRESS: 59 E. Main St Frostburg, Md.

DATE SIGNED: 9/2/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: 9-5-1949

NAME OF CEMETERY OR CREMATORY: St. Michaels

LOCATION (City, town, or county) (State): Frostburg Md

DATE REC'D BY LOCAL REG. 9-3-49

REGISTRAR'S SIGNATURE: Mrs. Nancy K. Roe

24. FUNERAL DIRECTOR: Jacob Hafer

ADDRESS: Frostburg, Md.

RECEIVED
SEP 6 1949
BUREAU V. S.

Within corporate limits: DR. JACOBSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08476

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

T

VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 1 DAY
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND, MARYLAND
STREET ADDRESS (If rural, give location): 732 NORTH MECHANIC ST.,

3. NAME OF DECEASED (Type or Print): (First) BETTY B. (Middle) (Last) WOLFE

4. DATE OF DEATH: (Month) SEPT (Day) 18 (Year) 19 49

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE

8. DATE OF BIRTH: APRIL 1884

9. AGE last birthday: 65 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: HIRAM WOLFE

14. MOTHER'S MAIDEN NAME: VIRGINNIA HITE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: 9/17/49

832a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/17, 19 49, to 9/18, 19 49, that I last saw the deceased alive on 9/18, 19 49, and that death occurred at 7 25 P.m., from the causes and on the date stated above.

SIGNATURE: Samuel Jacobson — (Degree or title) MD — ADDRESS: 50 Pershing St — DATE SIGNED: 9/19/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Sept. 21-49 — NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery — LOCATION (City, town, or county) (State): Cumberland Allegany Maryland

DATE REC'D BY LOCAL REG.: Sept. 21, 1949 — REGISTRAR'S SIGNATURE: Everett R. Frantz, M.D.

24. FUNERAL DIRECTOR: J. Wm. T. Wolford — ADDRESS: Cumberland Md

RECEIVED
SEP 27 1949
BUREAU V. S.